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AUTHOR	Hansen, William: Resendez, Ignacio
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ABSTRACT

Intended as a guide in the development of a program of health services for migrant children, this operations manual designed by the State of Washington presents definitions, operational procedures, standards by which quality uniform physical examinations and linkage to health care systems can be established, and forms to be used in the program. Washington's program, which will build over the next five years, is predicated on the cooperative efforts of schools, Rural Health Clinics, State and local health agencies, and the interest of key professional people from medicine and education. The Migrant Education staff has structured the formal relationship between schools, Rural Health Clinics, and the County Health Departments so children and their parents can be included in already existing health care delivery systems. The relationship between schools, clinics, and the migrant education program is established by a written agreement. The schools identify the children, provide initial screening, and complete Migrant Student Record Transfer System records. The clinics, private physicians, and a mobile van team provide physical examinations and related laboratory work. (Author/CM)

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STATE OF WASHINGTON

MIGRANT EDUCATION

PHYSICAL EXAMINATION MANUAL

RC 01 2525

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STATE OF WASHINGTON

MIGRANT EDUCATION

OPERATIONS HANDBOOK
FOR
MIGRANT STUDENT MEDICAL SERVICES

MSRTS and Health Services
Migrant Education Center
1110 South 6th St.
Sunnyside, Washington
98944

Migrant Education
Grants Management Section
Office of State Superintendent of Public Instruction
Olympia, Washington
98504

funded under ESEA, Title I, Migrant P.L. 95-561

October, 1979

by

William Hansen
Ignacio Resendez

Table of Contents

	Page
Introduction	A
Definitions	B
Priorities	C
Service Models	D
Contract for Clinic Services	E
Physical Examinations	F
Work Plan	G
Organization of Van Team for Physical Examinations	H
Van Inventory	I
Standards	J
Appendix	

INTRODUCTION

The State of Washington, Migrant Education has taken the initiative to develop a program of health services which will dramatically affect migrant health needs. This program which will build over the next five years is predicated on the cooperative efforts of schools, Rural Health Clinics, State and local health agencies and considerable interest of key professional people from medicine and education. The program will ultimately include medical and dental services, nutrition and health education for students and parents. The first phase of the program has been deliberately aimed at perhaps the most difficult of all aspects of any health package for migrants; the linkage with a health care delivery system. Migrant Education staff has structured the formal relationship between schools, Rural Health Clinics, and the County Health Departments so children and their parents can be included in already existing health care delivery systems.

Migrant children remain the unseen and underserved population in our American society. The growth and recognition of Migrant Education has been painfully slow. Of particular concern has been the lack of health care for migrant children. The child of a mobile farmworker does not fit into traditional structures such as Title XIX and Title XX DHEW Health Programs or State Social Service programs. The migrant child as seen in the State of Washington will demonstrate a high incidence of malnourishment, no health education, and limited basic health services. Perhaps fifty percent will not have seen a doctor since infancy.

The operations manual which follows is the definition of the structure which has been placed into operation. The manual intended as a planning guide, a set of operational procedures and perhaps most importantly a set of uniform standards by which quality uniform physical examinations and linkage to health care systems can be established.

The relationship between schools, clinics and the migrant education program is established by a written agreement. In essence the schools identify children, provide initial screening and complete MSRTS records. The clinics, private physicians and mobile van team provide physical examinations and related laboratory work.

The physical examination program was initiated in FY 78-79.

FY 78-79 was a formative year which focussed on the design and implementation of Health Services. The key elements developed were:

- Definition of Rural Health Clinic roles and responsibilities
- Written contractual services linking schools and clinics
- Definition of mobile van roles and responsibilities
- Physical examinations and related services to 3000 migrant children.

FY 79-80 will build on this beginning. Ultimate programming will include parent education, a comprehensive dental program and a statewide classroom project. However for 79-80 the priorities in rank order are:

1. Full implementation of the physical examination and referral program including clinic contracts and van services. Some 5000 migrant children will be served. An operations manual will be completed which will define tasks and processes related to the physical examination program.
2. Provide in-service education to school health personnel. Quarterly in-service programs will be conducted.
3. Establish pilot classroom programs which focus on health and nutrition. Concepts and program elements critical to migrant health will be identified. Initial steps will be taken to identify functional materials. Patient education materials will be developed to orient children to the physical examination process.
4. Dental services will be initiated through linkage with U. of Washington dental school and a process for expanded dental services will be explored.

This operations manual is presented with a logical flow of information: definitions to procedures to standards. Included are forms which have been developed as part of the program.

The intent is to evolve a logical, simple structure which will serve migrant children throughout the United States.

DEFINITION OF MIGRANT CHILD

There are presently over 600,000 migrant children identified nationally on the Migrant Student Record Transfer System (MSRTS). The criteria used to determine the eligibility of a student as a "migrant" has been defined by federal code. The following criteria were extracted from Part 116d of Title 45 of the Code of Federal Regulations which was amended on September 25, 1978. Complete final regulations are recorded in the Federal Register, Part III, dated November 13, 1978 (see also the current state application for the annual program plans).

A migratory child is the child of a migratory agricultural worker or a migratory fisherman who moves with his family within a state or from one state to another for the purpose of finding temporary or seasonal employment.

A currently migratory child means a child:

(a) Whose parent or guardian is a migratory agricultural worker or a migratory fisher; and

(b) Who has moved within the past twelve months from one school district to another - or, in a State that is comprised of a single school district, has moved from one school administrative area to another - to enable the child, the child's guardian, or a member of the child's immediate family to obtain temporary or seasonal employment in an agricultural or fishing activity. This definition includes a child who has been eligible to be served under the requirements in the preceding sentence, and who, without the parent or guardian, has continued to migrate annually to enable him or her to secure temporary or seasonal employment in an agricultural or fishing activity.

A formerly migratory child means a child who:

(a) Was eligible to be counted and served as a currently migratory child within the past 5 years, but is not now a currently migratory child;

(b) Lives in an area served by a Title I migrant education project; and

(c) Has the concurrence of his or her parent or guardian to continue to be considered a migratory child.

An interstate migratory child is one who has moved with a parent or guardian within the past year across state boundaries...

An intrastate migratory child is one who resides in a state full time and who has moved with a parent or guardian within the past year across district boundaries within that state...

The migrant status classifications are as follows:

Class I = AGRICULTURAL INTERSTATE MIGRANT
Class II = AGRICULTURAL INTRASTATE MIGRANT
Class III = AGRICULTURAL 5-YEAR MIGRANT
Class IV = INTERSTATE MIGRATORY FISHERMAN
Class V = INTRASTATE MIGRATORY FISHERMAN
Class VI = 5-YEAR MIGRATORY FISHERMAN

Some rules pertain to the inclusion of formerly migratory children. Such children may participate in projects with currently migratory children if:

1) their participation will not prevent the participation of current migrants or diminish the effectiveness of programs for current migrants,

2) there is valid documentation on file as to their eligibility,

3) there is a parent's/guardian's signature on file indicating their consent to the child'd participation.

A migrant child must be under eighteen years of age or must not have completed high school to be eligible for services.[1] Extended child care centers and child development activities are limited to infants and pre-school migrant children.

[1] Code of Federal Regulations, Sec. 45, Part 116d, "Grants to State Educational Agencies for Programs to Meet the Special Educational Needs of Migratory Children," 1975.

PRIORITIES FOR SERVICE TO MIGRANT CHILDREN

The United States Office of Education (USOE) has established the priority of which migrant children are to be served. Current regulations are stated as follows:

> *A State and an operating agency shall serve eligible migratory children -- according to their needs -- in the following order:*
> *(1) School-aged currently migratory children. (Status I, II, IV and V)*
> *(2) School-aged formerly migratory children. (Status III and VI)*
> *(3) Preschool formerly migratory children. (Status I, II, IV, and V)*
> *(4) Preschool formerly migratory children. (Status III and VI)*

Following the spirit of the USOE regulations, the Local Education Agency (LEA) via the Superintendent or his/her designee determines which migrant children are to receive physical examinations. The health provider will provide examinations for migrant students selected by the LEA according to the priorities listed below. With the wide disparity of numbers of migrant children in school districts and the impact of enrollment during growing and harvest seasons, the degree to which migrant children are served will vary. Large districts may have to prioritize children based upon need and the date of the student's last physical examination, while smaller districts may be able to schedule migrant children from all classifications within a calendar year. The standards for LEAs shall be:

(1) Adherance to USOE regulations on service priorities.

(2) Migrant student need. Where the LEA identifies a child needing immediate medical attention, that child may receive a physical examination.

(3) Those migrant students who have not received a physical examination within the past year.

(4) Other migrant students as the schedule of the health provider allows.

SERVICE MODELS FOR PHYSICAL EXAMINATIONS

The physical examination program is established to provide an on-going pattern of tieing migrant children into existing health care delivery systems, thus alleviating the chronic problem of migrant health.

The general pattern of the physical examination program is for school districts to refer eligible migrant children to rural health clinics or other health care organizations whenever a need is identified. School personnel initiate the physical examination form. The clinics as part of their contractual agreement with migrant education provide physical examinations. Follow-up or referrals as a result of the initial examination are the responsibility of the clinics. Students are served according to the priorities established by USOE.

Once the growing and harvest seasons begin, the impact of numbers generally preclude the transporting of children. It becomes more efficient and cost effective to provide examinations to the large numbers of children at the school site. The State of Washington has evolved four models which define the services available to schools at school settings. Differing organizational patterns dictate the model to be applied to a given school. These patterns may be identified by two critical variables; 1) the availability of a school nurse and other support personnel and 2) the availability and proximity of rural health clinic services.

In districts where school nurse, records clerk and home visitors are employed; the patient loads, the pre-examination nursing assessment, and scheduling are managed locally prior to the arrival of an examination team. The school nurse usually manages the school pre-examination activities. Where no nurse is available and other staff time is limited, the examining team must include pre-examination screening as part of their activities. This variable dramatically affects the number of children who can be examined. With appropriate school district staff available examining teams, with one examiner, can average 50 to 60 children a school day. With limited district assistance, the average number of children seen drops to 25 to 35 a school day.

The second variable is the type of examination team, whether rural health clinic or migrant medical van. Each of the six rural health clinics in Washington

is contracted to provide physical examinations to migrant children. Subsequent referrals and/or treatment are handled by the clinics as part of their regular service. Migrant children and their families are part of the potential service clientele of the rural health clinics. Therefore, a child seen by the clinic staff as part of the migrant education physical examination program may become a client of the clinic. Once the student has been introduced into the health care delivery system of the rural health clinic, further follow-up and/or referral is provided by the clinic. In instances where service is required beyond the scope of the clinic, the student may be referred by the clinic to a higher level of care. Rural Health Clinics serve specific geographic areas of the state. In those areas where no clinic service is available or where clinics request assistance due to numbers of students beyond clinic capacity then the migrant education medical van team is assigned to school districts.

The migrant medical van team is a direct service provided by migrant education to schools. The primary function of the team, like that of the clinics, is to provide physical examinations to migrant children. However, the migrant medical van team makes referrals to local health care delivery systems rather than providing follow-up and/or sophisticated treatment. Local school districts identify the available health care resources prior to the examination period. Such a system may be a local hospital, County Health Department, community clinic, or a local private practioner. When the van team is serving within a clinic service area, the referrals are made to that clinic. The van team thus insures that adequate follow-up can be provided to children who demonstrate a need.

The four models for service may be described as follows:

Migrant Medical Examination Service Models

	With School Nurse and staff	Without School Nurse and limited staff
Rural Health Clinic	Physical Examination Model 1	Physical Examination Model 2
Medical Van Team	Physical Examination Model 3	Physical Examination Model 4

Physical Examination Model 1

Model 1 is exemplary of the linkage established between a school district which employs a school nurse and other support personnel, and a rural health clinic with its comprehensive family health services including follow-up treatment where such is indicated. The procedures followed to implement Model 1 are:

	Implemented by		
	Migrant Health Office	School District	Rural Health Clinic
1. Identify school district and its school personnel by clinic service area.	X		--
2. Send a questionnaire to schools regarding district interest in participating in physical examination program.	X		
3. Identify eligible students (refer to service priorities).		X	
4. From questionnaire responses, model type is determined.	X		
5. Inform districts re: forms, eligibility, inservice schedule, and contact person.	X		
6. Inform County Health Department of the projected physical examination schedule for the purpose of providing follow-up on positive PPDs.			X
7. Schedule and provide inservice of forms utilization.	X		
8. Develop work plan including examination schedule times, locations, staffing, activities, patient flow, and supplies.		X	X
9. Prepare, distribute, and collect Student Health Notices.		X	
10. Follow-up on Student Health Notices that have not been returned to school.		X	
11. Complete unshaded portion of physical examination forms, to include transferring data from the Student Health Notice onto the physical examination form.		X	

		Implemented by		
		Migrant Health Office	School District	Rural Health Clinic
12.	Meeting between clinic and school district personnel to finalize patient flow.		X	X
13.	School and clinic cooperatively set up work stations.		X	X
14.	Select children from classes, and supervise flow through work stations.		X	
15.	School completes preliminary assessment if not completed prior to the time of the examination.		X	
16.	Clinic staff completes shaded portions of the physical examination form.			X
17.	Clinic provides necessary follow-up aftercare as identified in the initial physical examination.			X
18.	School nurse reads PPDs.		X	
19.	School nurse or her designee records PPDs on physical examination forms at clinic site.		X	
20.	Clinic personnel refer positive PPD readings to the County Health Department for follow-up.			X
21.	Monitor the follow-up on the positive PPD referrals to the County Health Department and record finding on M.S.R.T.S.		X	
22.	Separate copies of the physical examination form at the clinic site.			X
	a. Send original copy of the physical examination form to the Migrant Education Office.			X
	b. Send yellow copy of the physical examination form to parents.			X
	c. Send pink copy of the physical examination form to the school.			X
	d. Retain blue copy for clinic files.			X
23.	Transfer physical examination data onto the M.S.R.T.S. records to include PPD results, and file student materials.		X	

		Implemented by		
		Migrant Health Office	School District	Rural Health Clinic
24.	Reimburse the clinic for completed physical examinations.	X		
25.	Original copies of the physical examination form are alphabetized and categorized per school district and clinic service area for the purpose of statistical analysis.	X		
26.	Technical assistance on the implementation of the physical examination process is provided on an ongoing basis to the schools.	X		
27.	Technical assistance on the implementation of the physical examination process is provided on an ongoing basis to the clinics.	X		
28.	For those children requiring follow-up aftercare, the clinic will report to the school district that the care has been initiated for the purpose of recording this information on the M.S.R.T.S.	X		

Physical Examination Model 2

Model 2 is exemplary of the linkage established between a school district which has limited school staff, usually without services of a school nurse, and a rural health clinic with its comprehensive family health services including follow-up aftercare where such is indicated. It may be noted that the clinic staff must assume a more involved role than in Model 1. The procedures followed to implement Model 2 are:

	Implemented by		
	Migrant Health Office	School District	Rural Health Clinic
1. Identify school district and its school personnel by clinic service area.	X		
2. Send a questionnaire to schools regarding district interest in participating in physical examination program.	X		
3. Identify eligible students (refer to service priorities).		X	
4. From questionnaire responses, model type is determined.	X		
5. Inform districts re: forms, eligibility, inservice schedule, examiantion schedule, and contact person.	X		
6. Inform County Health Department of the projected physical examination schedule for the purpose of providing follow-up on positive PPDs.			X
7. Schedule and provide inservice of forms utilization.	X		
8. Develop work plan including examination schedule, times, locations, staffing, activities, patient flow, and supplies.		X	X
9. Prepare, distribute, and collect Student Health Notices.		X	
10. Follow-up on Student Health Notices that have not been returned to the school.		X	
11. Complete unshaded portion of physical examination forms to include transferring data from the Student Health Notice onto the physical examination form.		X	X
12. Clinic and school district personnel meet to finalize patient flow.		X	X
13. School and clinic cooperatively set up work stations.		X	X

		Implemented by		
		Migrant Health Office	School District	Rural Health Clinic
14.	Select children from classes, and supervises flow through work stations.		X	
15.	Clinic staff completes unshaded portion of the preliminary assessment.			X
16.	Clinic staff completes shaded portions of the physical examination form.			X
17.	Clinic provides necessary follow-up aftercare as identified in the initial physical examination.			X
18.	Clinic staff returns to schools and reads PPDs.			X
19.	Clinic staff records PPDs on physical examination forms at the clinic site.			X
20.	Clinic staff refers positive PPDs to local County Health Department for follow-up.			X
21.	Monitor the follow-up on the positive PPD referrals to the County Health Department and record findings on the M.S.R.T.S.		X	
22.	Separate copies of the physical examination form at the clinic site:			X
	(a) Send original copy of the physical examination form to the Migrant Education Office.			X
	(b) Send yellow copy of the physical examination form to the parent.			X
	(c) Send pink copy of the physical examination form to the school.			X
	(d) Retain blue copy for clinic files.			X
23.	Transfer physical examination data onto the M.S.R.T.S. records and file student materials.		X	
24.	Reimburse the clinic for completed physical examinations.	X		
25.	Original copies of the physical examination form are alphabetized and categorized per school district and clinic service area for the purpose of statistical analysis.	X		

		Implemented by		
		Migrant Health Office	School District	Rural Health Clinic
26.	Technical assistance on the implementation of the physical examination process is provided on an ongoing basis to the schools.	X		
27.	Technical assistance on the implementation of the physical examination process is provided on an ongoing basis to the clinics.	X		
28.	For those children requiring follow-up aftercare, the clinic will report to the school district that the care has been initiated for the purpose of recording this information on the M.S.R.T.S.	X		

Physical Examination Model 3

Model 3 is a service model with the Migrant Education Medical Van Team providing examinations in school settings with the assistance of a school nurse and other support staff.

		Implemented by		
		Migrant Health Office	School District	Mobile Medical Van
1.	Identify school districts and its school personnel by van service area.	X		
2.	Send a questionnaire to schools regarding district interest in participating in the physical examination program.	X		
3.	Identify eligible students (refer to service priorities).		X	
4.	Determine type of model from questionnaire responses.	X		
5.	Inform districts re: forms, eligibility, inservice schedule, examination schedule, and contact person.	X		
6.	Inform County Health Department of the projected physical examination schedule for the purpose of providing follow-up on positive PPDs.	X		
7.	Schedule and provide inservice on forms utilization.	X		
8.	Develop work plan including times, locations, staffing, activities, patient flow and supplies.		X	X
9.	Prepare, distribute, and collect Student Health Notice.		X	
10.	Follow-up on Student Health Notices that have not been returned to school.		X	
11.	Complete unshaded portion of physical examination forms to include transferring data from the Student Health Notice onto the physical examination form.		X	
12.	School and medical van staff cooperatively set up work stations.		X	X
13.	Supply, equip, and move mobile medical van onto school site.			X
14.	Select children from classes and supervise flow through work stations.		X	

		Implemented by		
		Migrant Health Office	School District	Mobile Medical Van
15.	School completes preliminary assessment if not completed prior to the time of the examination.		X	
16.	Complete the shaded portion of the physical examination form.			X
17.	At the completion of the physical examinations, the van examiner meets with the school nurse to discuss identified problems and prescribed medications.			X
18.	School nurse insures that follow-up is initiated on students requiring follow-up care.		X	
19.	School nurse reads PPDs.		X	
20.	School nurse or her designee records PPDs on the physical examination forms.		X	
21.	School nurse refers positive PPDs to the County Health Department for follow-up.			X
22.	Monitor the follow-up on the positive PPD referrals to the County Health Department and record findings on the M.S.R.T.S.		X	
23.	Separate copies of the physical examination form at the school site and promptly disseminates.		X	
	(a) Send original copy to the Migrant Education Office within one week after the physical examination date.		X	
	(b) Send yellow copy to the parents.		X	
	(c) Retain pink copy at the school.		X	
24.	Transfer physical examination data onto the M.S.R.T.S. record to include PPD results, and file student materials.		X	
25.	Original copies of the physical examination form are alphabetized and catagorized per school district, and van service area for the purpose of statistical analysis.	X		X

	Implemented by		
	Migrant Health Office	School District	Mobile Medical Van
26. Technical assistance on the implementation of the physical examination process is provided on an ongoing basis to the schools.	X		

Physical Examination Model 4

Model 4 is a direct service model with the Migrant Education Medical Van Team providing examinations in school settings where the district has limited staff and are usually without the services of a school nurse. It may be noted that the van team must assume a more involved role than in Model 3.

		Implemented by		
		Migrant Health Office	School District	Mobile Medical Van
1.	Identify school districts and it's school personnel by van service area.	X		
2.	Send a questionnaire to schools regarding district interest in participating in physical examination program.	X		
3.	Identify eligible students (refer to service priorities).		X	
4.	Determine type of model from questionnaire responses.	X		
5.	Inform districts re: forms, eligibility, in-service schedule, examination schedule, and contact person.	X		
6.	Inform County Health Department of the projected physical examination schedule for the purpose of providing follow-up on positive PPDs.	X		
7.	Schedule and provide in-service on forms utilization.	X	X	
8.	Develop work plan including locations, staffing, activities, patient flow, and supplies.		X	X
9.	Prepare, distribute, and collect Student Health Notice.		X	
10.	Follow-up on Student Health Notices that have not been returned to school.		X	
11.	Complete unshaded portion of the Physical Examination Forms, to include transfering data from the Student Health Notice onto the Physical Examination Form.		X	
12.	Supply, equip and move Mobile Medical Van onto school site.			X
13.	School and medical van staff cooperatively set up work stations.		X	X

		Implemented by		
		Migrant Health Office	School District	Mobile Medical Van
14.	Select children from classes and supervise flow through work stations.		X	
15.	Van staff completes unshaded portion of the physical examination form.			X
16.	Van staff completes the shaded portion of the physical examination form.			X
17.	At the completion of the physical examinations, the van examiner meets with school home visitor to discuss identified problems and prescribed medications.		X	X
18.	School home visitor and van examiner arrange for necessary follow-up on identified referrals.		X	X
19.	Van staff returns to school and reads PPDs.			X
20.	School staff member records PPDs on physical examination forms.		X	
21.	Van personnel refer positive PPDS to the County Health Department.			X
22.	Monitor the follow-up on positive PPD referrals to the County Health Department and record findings on the M.S.R.T.S.		X	
23.	Copies of the physical examination for follow-up form are separated.	X		
	(a) Send original copy to the Migrant Education Office within one week after the Physical Examination date.		X	
	(b) Send yellow copy to the parents.		X	
	(c) Retain pink copy at the school.		X	
24.	Transfer physical examination date onto the M.S.R.T.S. record to include PPD results and file student materials.		X	
25.	Original copies of the physical examination forms are alphabetized and categorized per school district and van service area for the purpose of statistical analysis.		X	

	Implemented by		
	Migrant Health Office	School District	Mobile Medical Van
26. Technical assistance on the implementation of the physical examination process is provided on an ongoing basis to the schools.	X		

Time Line

The implementation of the examination schedule can be scheduled over an eight week period. A three week period is taken to contact a district and receive their agreement to participate. Once the agreement is reached, then a work plan is developed. From that point, two to four weeks is required to complete the unshaded protions of the physical examination form. The length of time will vary based on the number of students to be seen, district processes in communicating with parents, and the available district personnel assigned to perform their activities contingent on their respective service model. The planning is designed to allow for physical examinations to take place during peak impaction periods and thus reach the maximum number of migrant children as possible. Type III migrant children are usually scheduled during non-impaction periods. Note that the parental consent for the physical examination, lab work, and PPD skin test are now included in the State of Washington Certificate of Pupil Eligibility (COE or CPE) and therefore, separate parental consent forms are not required. This minimizes the time required for data gathering.

Time Line For Implementing Health Services

Activity Sequence	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
1. Pre-impaction planning	X							
2. Initial contacts and Organization by Migrant Health Office		X	----------	X				
3. Local District Organization and data gathering			X	----------	----------	X		
*4. Examinations					X	----------	X	
*5. Post examination data and follow-up						X	----------	X

* Time assigned will vary depending on schedule and completion of pre-examination factors.

Health Clinic Contracts and Billing Procedures

Rural Health and Community Service Clinics are contracted to provide physical examinations for migrant children. The contractual agreement details the responsibilities of the clinics, the cooperating schools, and migrant education. The contractual agreement is renegotiated each year. (See sample which follows.) Contracted clinics secure reimbursement through a procedure, jointly developed by Migrant Education and Sunnyside School District, the fiscal agent.

The mobile health van furnished by Migrant Education is a direct service. Those districts served by the van team do not follow the same fiscal arrangements as do districts in the clinic service areas.

STATE OF WASHINGTON
MIGRANT EDUCATION PROGRAM
701 NORTH AVENUE, SUNNYSIDE, WASHINGTON 98944
MIGRANT EDUCATION IDENTIFICATION AND RECRUITMENT
509-837-5552
MIGRANT STUDENT RECORD TRANSFER SYSTEM AND HEALTH SERVICES
509-837-2712

PHYSICAL EXAMINATION CONTRACT

The purpose of this agreement is to (1) provide continuity and quality health care to the migrant children within the State of Washington, (2) promote utilization of existing health resources by establishing linkages, and (3) enable interdepartmental cooperation to exist within projects of the Department of Health, Education, and Welfare.

This agreement is entered into by and between the

hereinafter called the Migrant Health Clinic and the Sunnyside School District #201 Migrant Education Program, Migrant Records Office hereinafter called Migrant Education. This contract shall be in force from August 15, 1979, to July 31, 1980, and will supercede the previous Physical Examination Contract signed by the Clinic Director and dated February 27, 1979.

The Migrant Health Clinic will provide health screenings and physical examinations to migrant student enrollees as per the Washington State Migrant Student Medical Record. These examinations will usually take place at the school site and will be provided by a Migrant Health Clinic Medical Team. However, provisions shall be made between the Migrant Health Clinic and the ccoperating schools for scheduling of new migrant students who enroll during the regular school year.

The following are the terms of this contract:

hereby agrees to:

1. Provide health screenings and physical examinations to a maximum of 3,000 children, as identified by the Local Education Agency and the Migrant Education Program. The physicals are to be provided by the Clinic Staff at the school sites where possible.

2. Provide the core medical teams, including medical provider or mid level provider, to complete health screenings and physical examinations.
3. Provide the materials, equipment, and medical supplies essential to the examination process.
4. Meet with school personnel to plan and organize the patient flow of their team at each examination site.
5. Complete the shaded portions of the Physical Examination Form with the exception of the parasitic screen, the lead screen, and the sickle test.
6. Send the original copy of the Washington State Migrant Student Medical Record to the Migrant Education Office, 701 North Avenue, Sunnyside, Washington, 98944, for reimbursement. Send the yellow copy to the parents, the pink copy to the school, and retain the blue copy for the clinic's records.
7. Complete the following Tuberculin procedures:
   (a) administer Tuberculin skin tests (PPD).
   (b) inform the school personnel of those students who received PPDs within 24 hours after the examination.
   (c) read PPDs in those schools where there is no school nurse available and record all PPD findings on the Physical Examination Form for all children.
   (d) refer any positive PPD readings to the County Health Department.
8. Provide follow-up care where such is indicated. It is the responsibility of the clinic personnel to relay this information to the parents, encourage them to seek medical care for the child, and inform them of the cost as outlined below in item number (9). For those children found to have a condition requiring medication as part of follow-up aftercare, it is the responsibility of clinic personnel to give prescriptions to parents and encourage them to have them filled. For follow-up aftercare beyond the scope of the clinic, the clinic personnel will be responsible for informing the parents and making the necessary arrangements. For

those children requiring follow-up aftercare, the clinic will report to the school that this care has been initiated for the purposes of recording this information on the M.S.R.T.S.

9. Bill the parents for all costs for follow-up services beyond the initial physical examination. These costs will be subject to the sliding fee scale of the

The Migrant Education Program/Cooperating School Districts agree to:

1. Determine eligibility of all students who are referred for a physical examination. It is understood that a participating migrant child is:
   (a) eligible as defined by the United States Office of Education.
   (b) a child who has received a physical examination in the past calendar year is not eligible to receive another physical examination during the same calendar year.
2. Reimburse the at $8.00 per child for each physical examination provided at the school.
3. Reimburse the at $3.00 per child for each physical examination provided at the clinic for those children referred by the school.
4. In cooperation with the local school districts, provide patient histories necessary for completing the Washington State Migrant Medical Form.
5. With cooperating schools, provide for the examinations:
   (a) space in schools for health screenings and physical examinations to take place.
   (b) tables, chairs, and other furniture that is appropriate.
   (c) family information for the Student Health Notice obtained from parents.
6. Upon being informed by the clinic of those children who have received Tuberculin (PPD) skin tests, the school nurse shall

read the PPDs and the school nurse or authorized personnel shall inform the clinic of the children who had their PPDs read and which of those children had positive reactions.

7. Monitor the follow-up of those positive PPD referrals to the County Health Department and record findings and/or results on the M.S.R.T.S.
8. Have all medical information placed into the Migrant Student Record Transfer System.

M.S.R.T.S. and Health Services Supervisor _____ Date _____

Executive Director, _____ Date _____

Administrative Assistant, Sunnyside School District #201 _____ Date _____

Clinic Reimbursement Procedures

The Migrant Education Center maintains a master file which includes the original of the contract in force. The contracted clinic submits the original copies of physical examination forms by the 10th of each month. (e.g., All physical examinations completed during the month of June must be turned into the bookkeeper by June 31). Upon receiving the original copies of the physical examination form, the bookkeeper alphabetizes them by school district within clinic service areas. The billing statement is completed by clinic personnel and mailed to the bookkeeper (see example which follows). This statement includes the provider agency, the date of the physical examination, alphabetized list of children served, and the amount charged to the providing agency. The bookkeeper makes three copies of the billing statement. The original billing statement is filed in the billing register at the Migrant Education Center. One copy is attached to the physical examination forms. One copy is returned to the clinic with the payment for services. The remaining copy is filed in the Sunnyside School District #201 Business Office. At the end of the month, a purchase order is completed for each clinic which includes the number of children who received the physical examination, the amount of reimbursement per child, and the total amount of reimbursement for all the children who received physical examinations. The reimbursement is made upon signature of the M.S.R.T.S./ Health Supervisor and the Administrative Assistant of Sunnyside School District #201. A green copy of the purchase order is filed with the original copy of the billing statement. Thus billing is completed and auditable records are available for inspection at the Migrant Education Office.

Record and Data Maintenance

All official records and auditable data are maintained under the Supervisor of M.S.R.T.S./Health Services at the Migrant Education Center.

Clinic Inservice

The bookkeeper shall inform all clinics of the clinic reimbursement procedure at the beginning of each contract period.

BILLING STATEMENT

Physical Examinations Provided By: Name of Clinic
Physical Examination Site: Location
Date Physical Examinations Completed: Date

Child	Fee
1. Child's name	$00.00
2. " "	00.00
3. " "	00.00
3 Examinations @ $00.00 =	$ 00.00

SUNNYSIDE SCHOOL DISTRICT NO. 201

SUNNYSIDE, WA. 98944

PURCHASE ORDER No. 09462

TO
Clinic Name
Clinic Address
City, State, Zip Code

9/1/79

Migrant Education
701 North Avenue
Sunnyside, WA 98944

		EXAMINATIONS ON CHILDREN:		
53		July 7 and 8, 1979	$00.00	$000.00
40		August 1 and 2, 1979	00.00	000.00
				$000.00

Line Item Code

SUNNYSIDE SCHOOL DISTRICT NO. 201

AUTHORIZED SIGNATURE

VENDOR

PHYSICAL EXAMINATION PROCESS

The physical examination is a three step process:

The first step is the completion of the unshaded portion of the Washington State Migrant Student Medical Record by school personnel. The second step is the completion of the shaded portion of the medical record by the examining medical team. The third step is the transferring of the information obtained through the physical examination process onto the M.S.R.T.S. record.

Step 1. (Note white areas on Medical Form.)

Prior to the physical examination, a child must have current data recorded on height, weight, vision, and hearing. In addition, the student description, child's history, birth history, and immediate family history should be completed and signed by school personnel. It should be noted that vision and hearing tests are mandated by law for selected grade levels in Washington. The school may have current test data on file which can be entered on the Migrant Student Medical Record.

Step 2. (Note shaded areas on Medical Form.)

The examiner and/or team members shall be responsible for gathering required specimens for lab results and blood pressure, pulse, temperature readings, and performing the physical examination. The examiner will mark "appears normal" or "abnormal" or "not examined" to indicate results of the examination. Examiner diagnosis, prescription, treatments, and/or referral will be noted in the Dear Parent section of the medical record.

Step 3.

The information recorded on the Washington State Migrant Student Medical Record is transferred onto the M.S.R.T.S. record at the school. This information should be transmitted to the national computer network (M.S.R.T.S.).

School District _____

Mobile Medical Van Work Plan

The following data is required for the scheduling of the mobile medical van. This work sheet is developed by the cooperation of the van staff and the cooperating school district.

Priorities

The school age migrant child is the primary client of the state migrant education medical examination program. Type I and II (mobile) students will be provided examinations during impaction periods with settled out (Type III) students scheduled for examinations in non-impaction periods whenever possible.

The basic service format is the rural health clinic contract. The student examined then becomes a client of the clinic for follow-up treatment and subsequent examinations.

The mobile clinic is a continuing direct service provided by migrant education for 1) areas where no rural health clinic exists, 2) schools within clinic service areas where service is not provided, and 3) in areas where clinic is unable to meet the demand.

Prescreenings and immunizations will be provided in the traditional manner by school nurses and other district staff (see models 3 and 4).

Examination Process Planning

Staff Responsible	Date Completed		
_____	_____	A.	Establish communication with County Health Department and/or Clinic.
_____	_____	B.	Provide consent forms in English and Spanish.
_____	_____	C.	Negotiate and secure contract with clinic.
_____	_____	D.	Identify clinic, its service area and school districts within service area.
_____	_____	E.	Follow-up on positive PPD tests.
_____	_____	F.	Assist on acquisition of medical supplies.
		G.	Methodology for follow-up
_____	_____		1. Referral to clinic or _____ (list possible provider)
_____	_____		2. Student summary to be completed. By whom _____

School Districts

Staff Assigned	Date Completed		
_____	_____	A.	Do they want to participate? Yes ___ No ___
_____	_____	B.	Letter sent to district along with tentative schedule.
_____	_____	C.	Site identified for the physical examinations.
_____	_____	D.	Number of schools to participate. _____ (Include names if identified.)
_____	_____	E.	Number of sites. _____
_____	_____	F.	Total number of children to participate. _____
_____	_____	G.	Will they transport the students if only one site is identified? Yes ____ No ____
		H.	Schedule and provide inservice on forms.
_____	_____		1. Medical Record (Physical Examination)
_____	_____		2. Student Health Notice.
_____	_____	I.	District Contact Person _____
			Phone _____

Schools (Attach a list of each school)

_____	_____	A.	Do they have a room available to do physical examinations? Yes _____ No _____
_____	_____	B.	Do they have a bed? Yes _____ No _____
_____	_____	C.	Do they have a toilet? Yes _____ No _____
_____	_____	D.	Do they have a sink? Yes _____ No _____
_____	_____	E.	Do they have chairs (6)? Yes _____ No _____

School (will complete)

_____	_____	A.	Nursing assessment. Yes _____ No _____
			Person Responsible _____
_____	_____	B.	Birth History. Yes _____ No _____
			Person Responsible _____
_____	_____	C.	Patient and Family History. Yes _____ No _____
			Person Responsible _____
_____	_____	D.	Student Description. Yes _____ No _____
			Person Responsible _____
_____	_____	E.	Screening for immunizations. Yes _____ No _____
			Person Responsible _____
_____	_____	F.	Scheduling of children. Yes _____ No _____
			Person Responsible _____

Staff Assigned	Date Completed		
_____	_____	G.	Send packets to parents with the necessary forms to be signed.
			Person Responsible _____
_____	_____	H.	Follow-up on those students that have not returned packets with signatures.
			Person Responsible _____
_____	_____	I.	Do follow-up on PPD.
			Person Responsible _____

M.E.I.R.P. Component will provide

		A.	Outreach/driver support for the duration of project.
_____	_____		1. Driving van. Yes _____ No _____
			Person Responsible _____
_____	_____		2. Transport children. Yes _____ No _____
_____	_____		3. Translate when necessary. Yes _____ No _____

Media

_____	_____	A.	News Release scheduled.
_____	_____	B.	School approval of news release
_____	_____	C.	Clinic Approval

Migrant Education Health Services Staff has

_____	_____	A.	Developed schedule.
_____	_____	B.	Informed all parties of schedule.
_____	_____	C.	Schedule and provide inservice on forms to schools.
_____	_____	D.	Order materials and supplies.
_____	_____	E.	Prepare and/or repair van.
_____	_____	F.	Establish patient flow chart with school.
_____	_____	G.	Recruit, interview, hire and orient mobile van staff.

MIGRANT EDUCATION MOBILE VAN

Outline for Work Plan

1. School District:

2. Dates:

3. Daily Times:

4. Number of Students:

5. Locations: (1) _____

(2) _____

(3) _____

6. Staffing:

School Staff	Migrant Education Staff
_____ A. School Nurse	_____ A. MD
_____ B. Clerk	_____ B. Nurse Practioner
_____ C. Home Visitor	_____ C. RN
_____ D. Other _____	_____ D. Health Aide
	_____ E. Outreach Worker

7. Activities

A. Prescreening to include:

Prescreening to be completed with van staff:

8. Work Flow (include person responsible and task assigned)

Station 1.

Station 2.

9. Supplies needed (include person responsible to acquire)

10. Attach chart showing work flow.

ORGANIZATION OF VAN TEAM FOR PHYSICAL EXAMINATIONS

The van team is organized to create a systematic process for the migrant child; beginning with the initial screening and finishing with the actual examination. Although staffing may change and/or physical limitation of a site may constrain the typical approach, the basic organization of physical examinations is as follows:

Station 1 - Screening: temperature, pulse and blood pressure.
Records are checked ready for processing.

Supplies required:
- Thermometer (2 electronic)
- Spare transistor battery for thermometer
- Thermometer probe disposable covers
- Garbage bag (for disposing probe covers)
- Stethoscope
- BP cuffs (adult and child sizes)
- Watch with second hand
- Pen
- Chair for child
- Chair for task performer
- Table
- Alcohol, Cotton balls } for disinfecting stethoscope

Managed by Health Aide or LPN

Station 2 - Screening: Height, Weight and Urinalysis

Supplies required:
- Table
- Chairs (2)
- Garbage bag and tape
- Uristix
- Height and Weight scale
- Marker
- Dixie Cups
- Bili-Labstix - acetone - blood, ph, glucose, protein, bilirubin
- Pen

Managed by Van Driver or Health Aide

Station 3 - Screening: Hct and PPD

Supplies required:

- Box for used syringes - used lancets
- Small box and small bandaids
- Dispenser and alcohol
- Dispenser, soap and water
- Cotton balls and dispenser
- Cooler - ice chest and PPD medications
- Thermometer
- Lancets
- Heparizined tubes
- Paper towel
- Clay hematocrit tube cards X 3-4
- Pen and red colored pen or pencil
- Notebook - Date, location, county, numeralized
  3 columns for immunizations, PPDs, Low Hcts.
- Micro hematocrit tube reading chart
- Centrifuge
- Needle cutter box
- Kleenex
- Syringes - 27 gauge 1/2"
- Epenephrine - Benedryl
- Tournique
- Chair and arm board
- Amononia salts (smelling)

Managed by RN or LPN

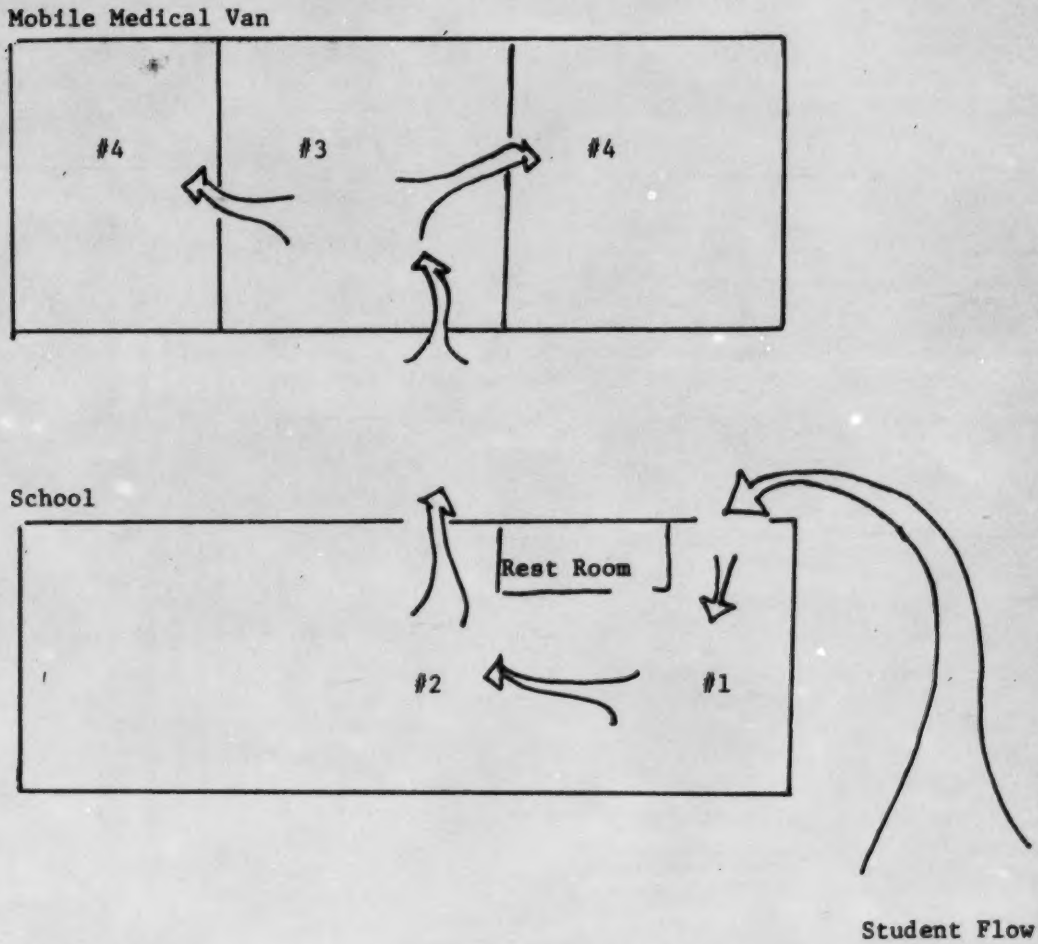
Station 4 - Physical examination

Supplies Required:

- Examination table
- Examination table paper
- Tongue blades with dispenser
- Cotton balls with dispenser
- Alcohol with dispenser
- Oto-opthalmascope
- Pen light
- Reflex hammer
- Ear curette
- Finger forceps
- Pen
- Prescription pad
- Q-tips
- Reference books (PDR and disease reference book)
- Handiwipes if running water not available
- Spare batteries
- Garbage basket and plastic bag
- Gloves (sterile and non-sterile)
- Medications
- Stethoscope

Managed by MD or NP

Sample Layout for Mobile Medical Examination



Key:

Station #1 = Form distribution and U.A. testing and recording

Station #2 = B.P., pulse and temperature

Station #3 = Hematacrit, P.P.D. and data collection

Station #4 = Physical examination

INVENTORY

Items needed for physical examinations are listed in three different inventory lists. One lists the items available in the migrant office. The second list is an inventory of items kept on the mobile van; while the third list contains items taken to a site when a physical examination room is provided in a school or clinic.

OFFICE MEDICAL INVENTORY:

- Alcohol
- Batteries
- Chemistrips
- Clay hematocrit cards
- Cotton balls
- Dixie cups
- Dixie cup dispenser
- Examination table paper
- Forms:
  - Migrant Insurance brochures
    - Spanish
    - English
  - Migrant Insurance claim forms
  - Physical examination form
  - Student Health Notice
- Garbage bags
- Hematocrit tubes
- Kleenex tissues
- Lancets
- Medications:
  - Ear Drops (analgesic)
  - Erythromycin
  - Fer-in-Sol
  - Penicillin (VK)
  - Sulfisoxazole
  - Vitamin C
  - Triple Antibiotic ointment
- Paper towels
- Paper Towel Dispenser
  - Roller type
- Syringes
  - 1 cc TB 27G 1/2
  - 3 cc 25G 5/8
- Thermometer Covers
- Tongue Depressors
- Uristix
- Vision tester
- Inner ear analyzer
- Ishara exam book

MOBILE MEDICAL VAN INVENTORY:

- Ace Bandage
- Alcohol
- Alcohol Dispensors
- Arm sling
- Band aids:
  - 3/4" x 3/4"
  - 3/4" x 3"
  - 1" x 3"
  - 3/8" x 1 1/2"
  - Juniors
- Batteries
- Blanket
- Bleach
- Blood Pressure Cuffs
- Blood Pressure Gauges
- Broom
- Bulbs
- Bulletin Board
- Centrifuge
- Chairs (folding)
- Chemistrips
- Clay hematocrit cards
- Cleansing Powder
- Cotton Balls
- Cotton Rolls
- Dixie Cups
- Dust Pan
- Ear Curette
- Electric Cord (100 ft.)
- Examination table paper
- Examination chair on wheels
- Finger Forceps
- Garbage Bags
- Gloves
- Hematocrit Tubes
- Kleenex Tissues
- Klings
- Lancets
- Medical Dictionary
- Medications:
  - Ampicillin
  - Allerfrin
  - Benadryl
  - Bromophen
  - Ear drops (analgesic)
  - Epinephrine
  - Erythromycin
  - Fer-in-Sol
  - Penicillin (VK)
  - Sulfisoxazole
  - Tetracycline
  - Vitamin C
  - Triple antibiotic ointment
- Mop
- Needle Cutters
- Oto-Ophthalmascope
- Paper Towels
- Paper Towel Dispenser
- Physicians Desk Reference
- Pillow
- Playmate Ice Box
- Prescription pads
- Scale (Height and Weight)
- Stapler and Staples
- Sterile Gauze Pads
  - 2" x 2"
  - 3" x 3"
- Stethoscope
- Syringes
  - 1cc TB 27G 1/2
- Table (folding)
- Tape
  - Adhesive
  - Plastic
- Thermometer Covers
- Thermometers
  - Electronic
  - Glass
- Tongue Depressors
- Tourniquet
- Uristix
- Waste Paper Baskets
- Zephrin

INVENTORY TAKEN WHEN EXAMINATION ROOM IS PROVIDED:

Alcohol
Band Aids
Benedryl
Blood Pressure Cuffs
Centrifuge
Clay hematocrit cards
Cotton balls
Dipstix
Dixie Cups
Ear Curette
Epinephrine
Examination Table Paper
Finger Forceps
Garbage Bags
Gloves
Hematocrit Tubes
Hematocrit Reading Graph
Kleenex Tissues
Lancets
Marking Pen
Measuring Tape
Needle Cutters
Oto-ophthalmascope
Pen light
PPD in cooler
Prescription Pads
Reflex Hammer
Scales
Soap
Stethoscope
Syringes and Needles
Syringe disposal box
Thermometer Covers
Thermometers
Tongue blades
tourniquet

STANDARDS FOR PHYSICAL EXAMINATIONS OF MIGRANT CHILDREN

The standards for processes of examination and recording of data which follow are to be utilized throughout the State of Washington. Many agencies cooperate in the physical examination and referral process (e.g., rural health clinic personnel, school nurses, county health departments, the migrant medical van team, etc.). The intent is to carefully define major elements of the examination process to ensure communication between health care personnel and to improve the quality of examination data.

The format for the standards sections is: 1) definition, 2) procedure, and 3) standards. Where ever possible an existing standard established within the medical community has been used.

Standards are presented for Urinalysis, Hematocrit, Blood Pressure, Height and Weight, Vision, Pulse, Temperature, Hearing and Tuberculin Testing. Scoliosis Screening and Immunizations as related to the Washington State Law are also reviewed.

BLOOD PRESSURE (BP)

Definition: The pressure exerted by the blood on the wall of any blood vessel.

Procedures: The blood pressure may be taken on arms or legs. The accepted procedure is to take blood pressure on the upper arm unless otherwise indicated (e.g., burns or injury). The examiner selects the correct cuff size to cover two-thirds of the upper arm and wraps it snuggly around the arm. The cuff is then inflated to a minimum of 20 mm of pressure greater than the standard BP for that age group (see attached chart). Once that pressure is reached and the stethoscope is in position on the brachial artery, the pressure is slowly released and the number of mm of pressure are recorded at the time the first and last heart sounds are heard. This must be done in a quiet place so the examiner can accurately hear.

1. Children 3 years old and older should have their blood pressure measured annually as part of their continuing health care.

2. Hypertension detection should be incorporated into the child's total health care program; high blood pressure detection programs per se for children should not be established. Referral and follow-up resources must be identified before detection activities begin.

3. Blood pressure measurements on infants and children should be taken in a quiet environment with the correct cuff size, and with the fourth phase Korotkoff sound used for the diastolic pressure.

4. Blood pressure measurements obtained should be recorded on appropriate blood pressure charts similar to those contained in this report, and their significance should be judged accordingly (Figs. 1 and 2).

5. Caution should be exercised in labeling children as hypertensive because of psychosocial and economic implications; use of the term "high normal blood pressure" is appropriate during evaluation and follow-up to avoid unnecessary negative implications.

6. Sustained blood pressure levels (obtained at least on three separate occasions) that are above the 95th percentile should be considered abnormal, with recognition that any cutoff point represents an arbitrary decision at any age.

7. In infants and children with sustained blood pressure above the 95th percentile, a medical history should be obtained, a physical examination performed, and further tests completed as outlined in this report to determine a possible cause and to develop an appropriate follow-up program.

8. Children with sustained elevated blood pressure should receive a systematic long-term follow-up program, which may include hygienic counseling covering weight control, salt intake, exercise and smoking, and antihypertensive pharmacotherapy when indicated.

9. Physicians who manage hypertensive children with pharmacotherapy should use the "stepped-care" approach, with emphasis on minimal effective dosages of appropriate agents.

10. Children at high risk of developing elevated blood pressure should be evaluated for other atherosclerotic risk factors and should be taught to observe necessary hygienic measures for lowering risk factors.

11. Nurses and other properly trained and supervised nonphysician health personnel should participate in the identification and management of children with elevated blood pressure.

12. Specific research in the field of blood pressure control in children should be encouraged and funded. For this purpose, guidelines for research in children should be developed, including the evaluation of new drugs and other methods of blood pressure control.

Reprinted from PEDIATRICS SUPPLEMENT, May 1977.

Prepared by the National Heart, Lung, and Blood Institute's Task Force on Blood Pressure Control in Children

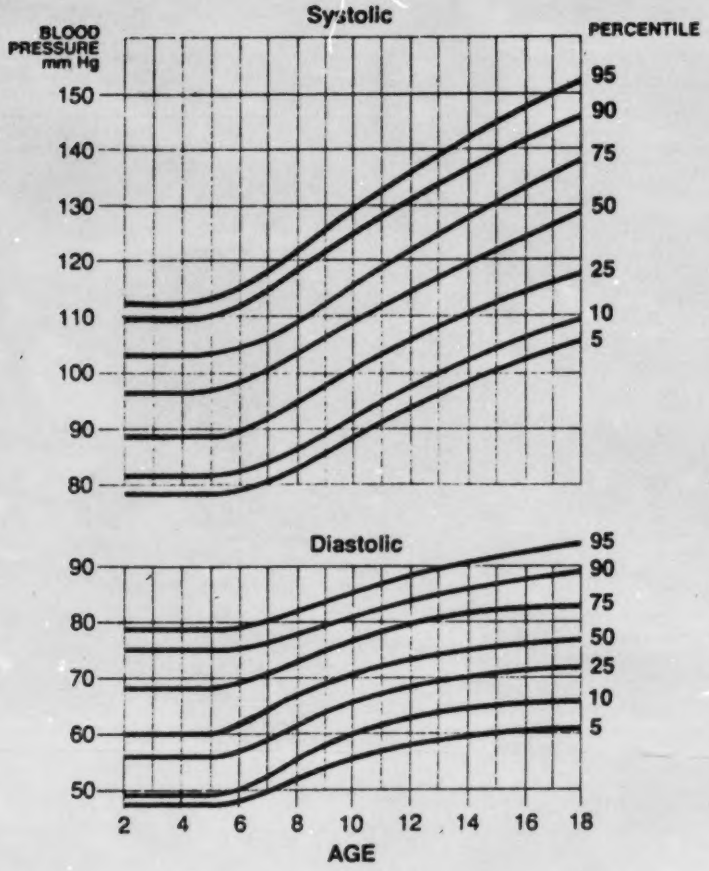


FIG. 1. Percentiles of blood pressure measurement in boys (right arm, seated).

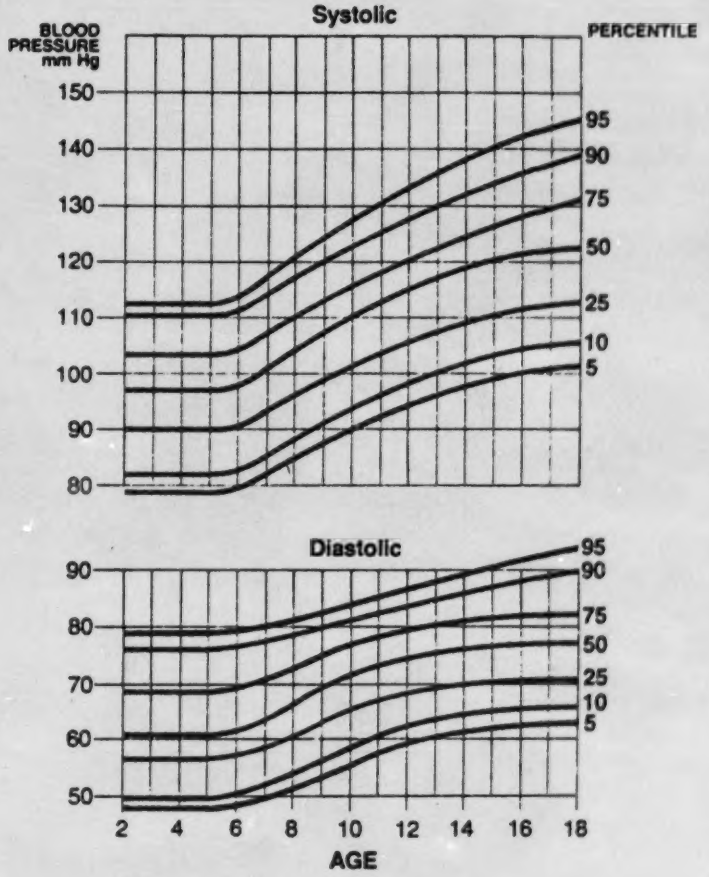


FIG. 2. Percentiles of blood pressure measurement in girls (right arm, seated).

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Supplied courtesy of Wyeth Laboratories

J-3

SUSPECTED ABNORMAL BLOOD PRESSURE LEVELS IN CHILDREN

Age	Pressure (mm Hg)
3-6 years	110/70
6-9 years	120/75
10-13 years	130/80

The approach to the asymptomatic hypertensive child depends on the degree of hypertension. If it is borderline, that is, between the 90th and 95th percentiles for age and sex, the reading is merely recorded and nothing said about it to the parent or child since frequently all subsequent blood pressures may be normal. If the pressure is high, that is, the systolic or diastolic pressure (or both) is 10 mm Hg or more above the 95th percentile, the child's blood pressure is measured once a month for 3 to 4 months. If the last blood pressure measurement is still elevated, or if in borderline cases the systolic or diastolic pressure is repeatedly above the 90th percentile and occasionally above the 95th percentile for a year or more, the child is considered to be hypertensive. Great care is exercised in the way the blood pressure findings are reported to the child and parent so as to avoid generating needless anxiety.

HEARING

Definition: Auditory acuity.

Procedure: Auditory screening is by law one aspect of a school's health program. By state code school age children are to receive auditory screening in kindergarten through the first three elementary grades. (WAC 248-748-020) In addition no longer than three years can elapse between screenings for children in grades four through twelve.

Children shall be screened at 1000, 2000 and 4000 Hz. A child not responding to one or more frequencies in either ear shall be rescreened within two weeks. Failure to respond at one or more frequencies at the second screening shall cause the child to be referred to a physician.

Note: State code requires that "all new students in a district regardless of grade level shall be screened as soon as possible after admission."

Standards: The hearing and responding to tones at 1000, 2000, and 4000 Hz is the satisfactory hearing standard. Where a quiet testing environment exists it is recommended that testing include 500 Hz stimulus.

HEIGHT AND WEIGHT

Definitions: Height is the measure of a person's stature. Weight is the measure of a person's heaviness.

Procedures: This data is needed by the examiner at the time of the examination for the purpose of assessing growth. The height and weight is therefore completed prior to the examination as part of the preliminary examination. The measures are made with the shoes removed. The height is recorded in inches; while the weight is recorded in pounds.

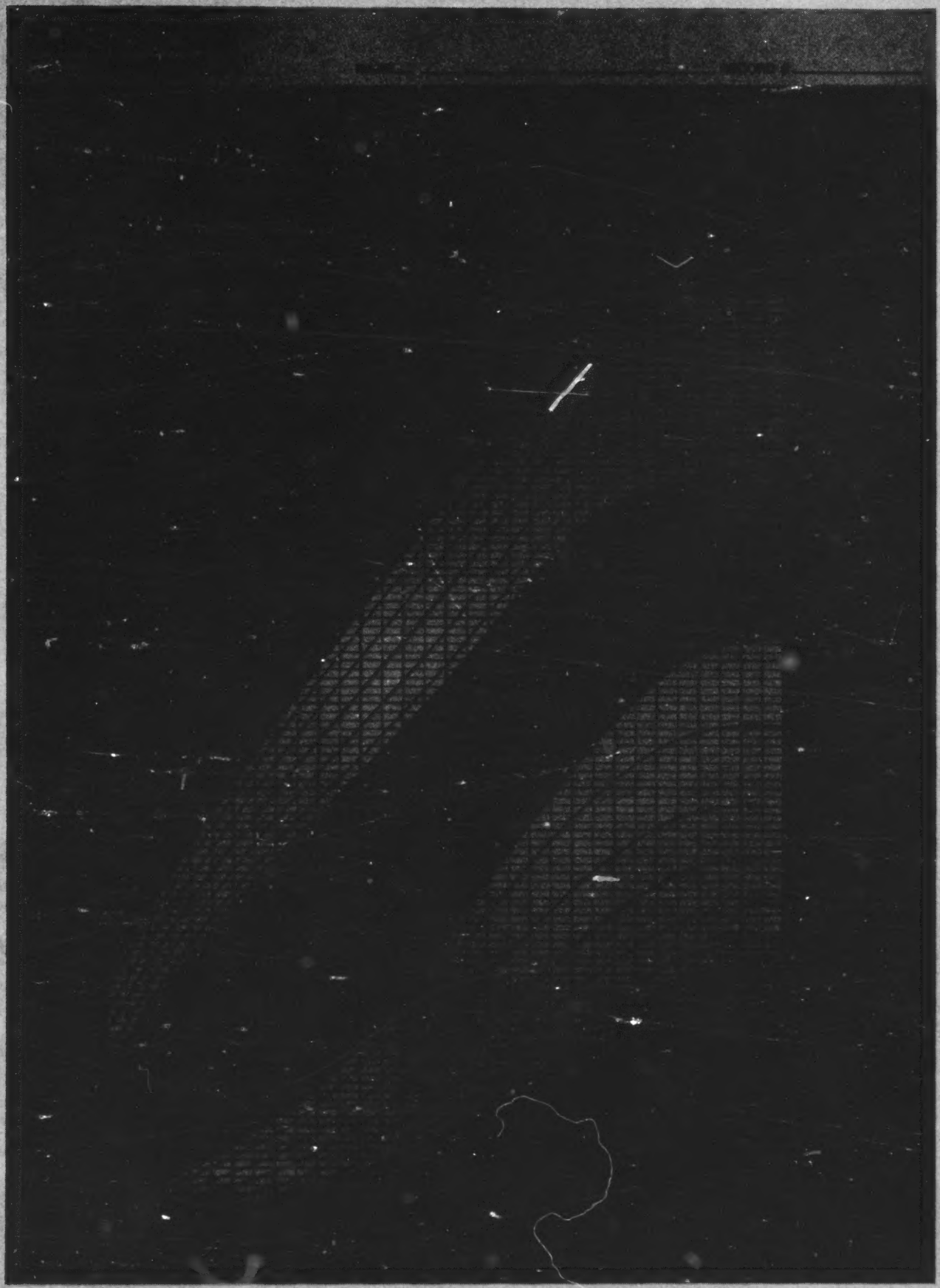
Standards: The charts which follow provide height and weight standards in relation to the age of a child. Where abnormalities occur notes should be made in the Dear Parent Section of the Physical Examination Form.

BEST COPY AVAILABLE

BEST COPY AVAILABLE

BEST COPY AVAILABLE

BEST COPY AVAILABLE



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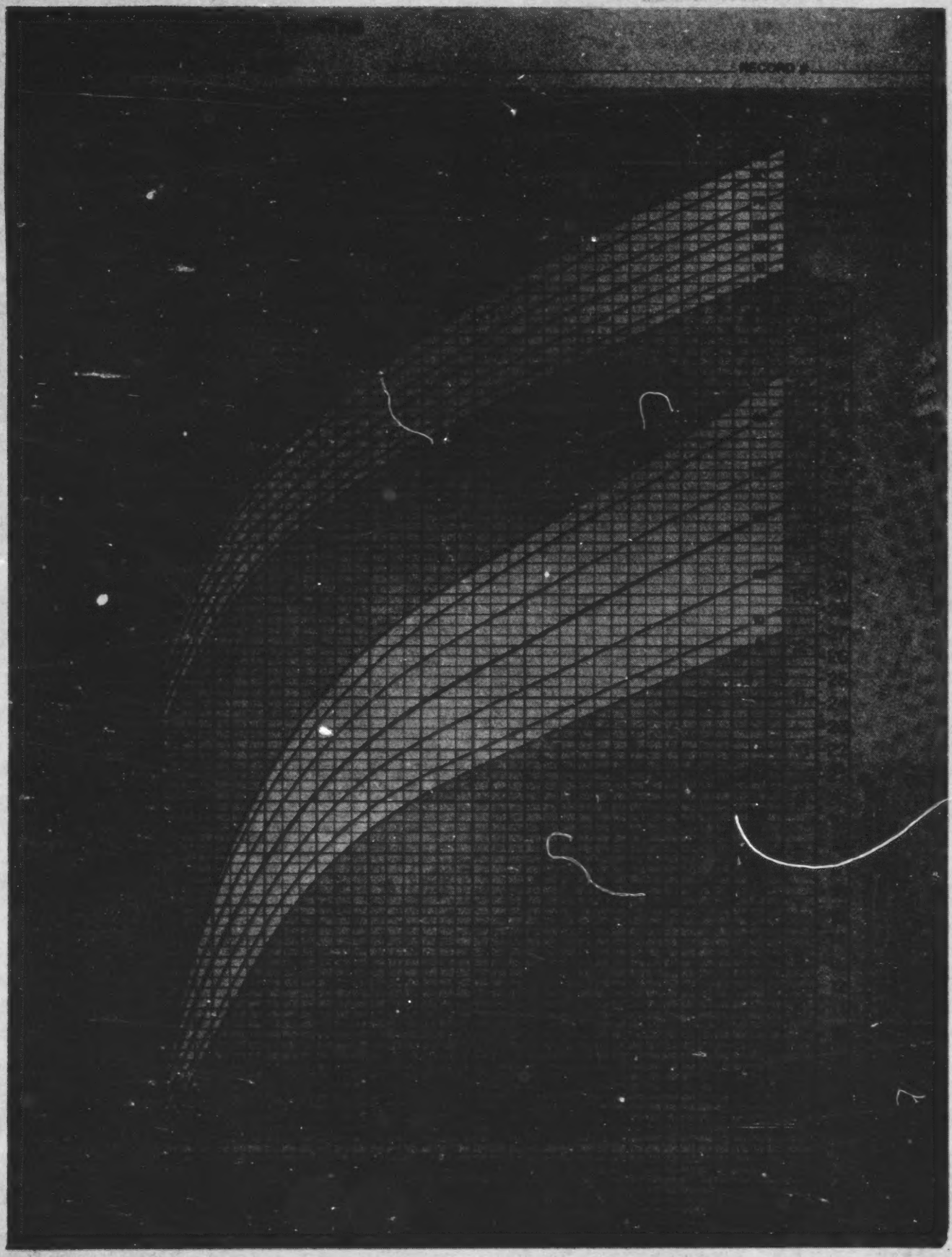

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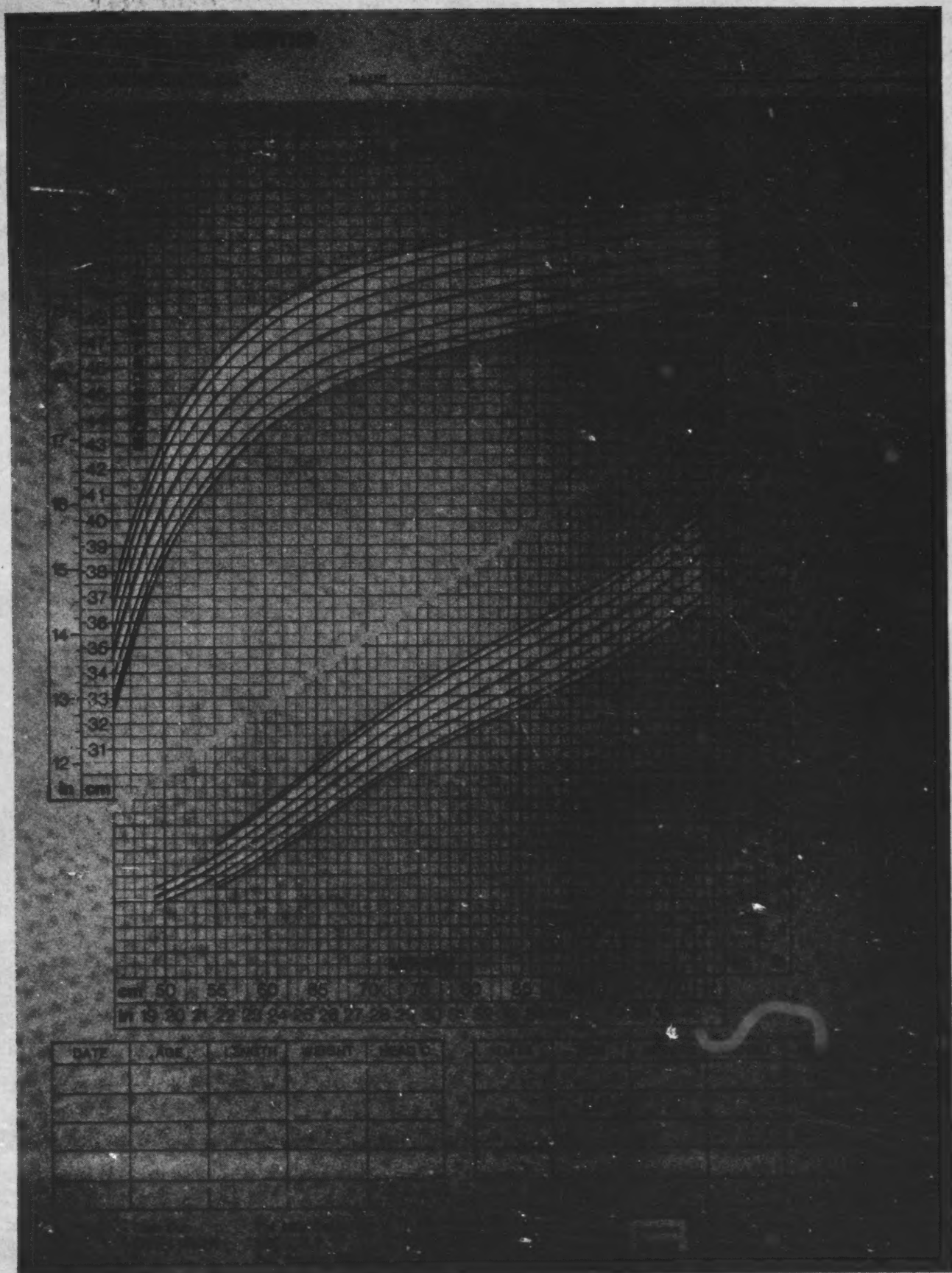

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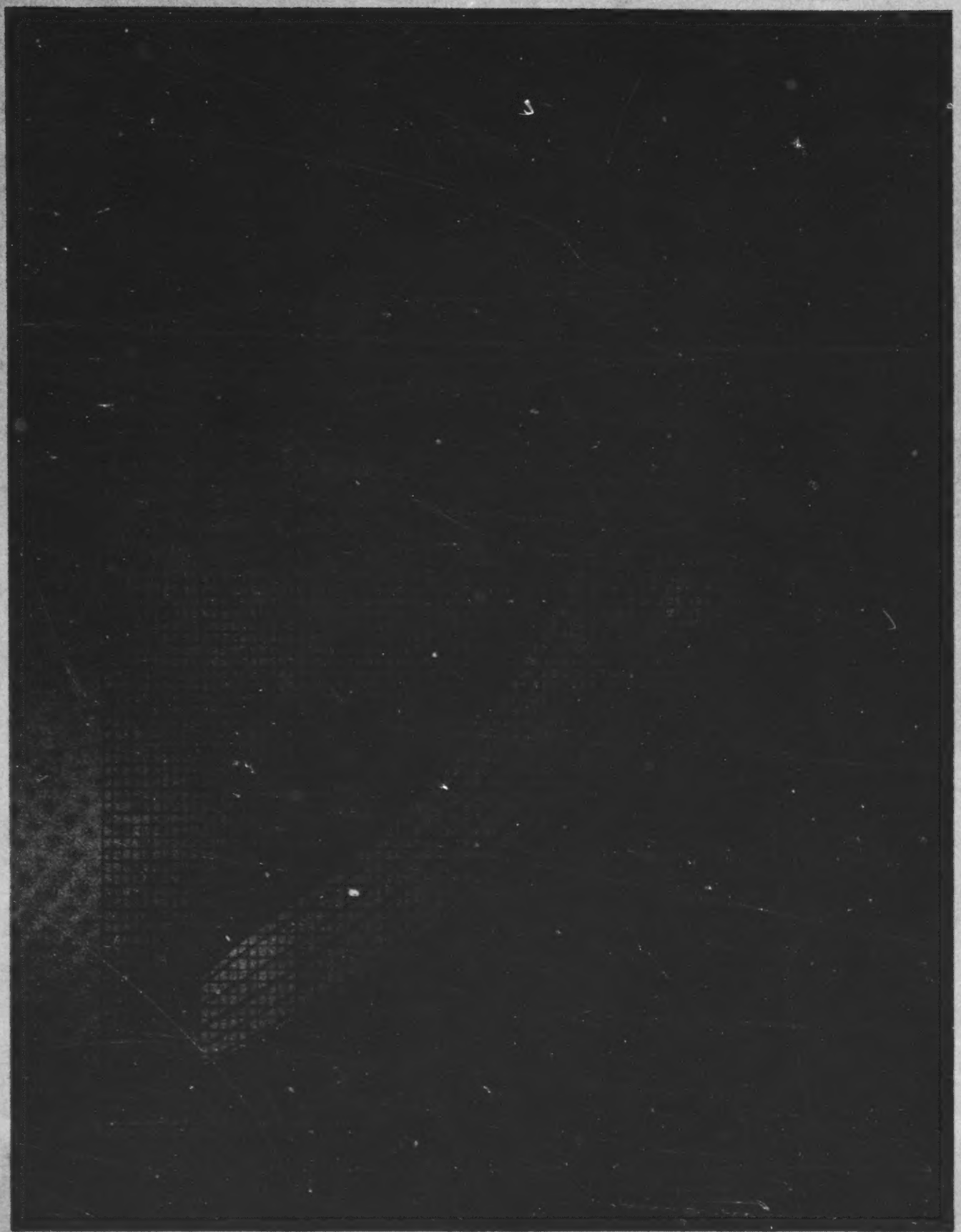

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HEMATOCRIT

Definition: The percentage of red blood cells (erythrocytes) packed by centrifugation, measured in cubic centimeters, for a given volume of blood.

Procedure: A sample of blood is obtained by puncturing the tip of the fourth finger with a lancet. The blood is then drawn into a heparinized plastic tube up to the indicated level and the end at which the blood entered is sealed with clay. The tube is then placed numerically and vertically on the clay card to identify it with the student and its placement in the centrifuge. When an adequate number of blood samples have been obtained, the tubes are placed in the centrifuge according to their identification numbers. When fewer blood samples have been obtained than the amount needed to fill the centrifuge, the empty spaces must then be filled with empty tubes in order for the centrifuge tray to be balanced. At this point, the lid is secured over the centrifuge tray and the outer cover is latched. The timer is set for a maximum of five minutes. At the completion of the allotted spinning time, the centrifuged micro-hematocrit tubes are placed certically on the Micro-Hematocrit Tube Reader with the sealed end just touching the red line below the "0" percent line. The tube is then moved along the chart until the meniscus of the plasma intersects the top of the "100" percent line. The height of the red cell layer is then read as percent cell volume. The percent of red cells is then recorded on the physical examination form and the used tubes are disposed of with care to prevent cross-contamination.

Standards:

Age	Hematocrit Packed RBC Volume (ml/100 mi blood)
30 - 50 days	42 $\pm$ 6
2 - 2 1/2 months	38 $\pm$ 4
3 - 3 1/2 months	37 $\pm$ 3
5 - 7 months	38 $\pm$ 3
8 months - 3 years	39 $\pm$ 2
5 years	37 $\pm$ 3
10 years	39 $\pm$ 3
Adult male	46 $\pm$ 3.1
Adult female	40.9 $\pm$ 3

PULSE

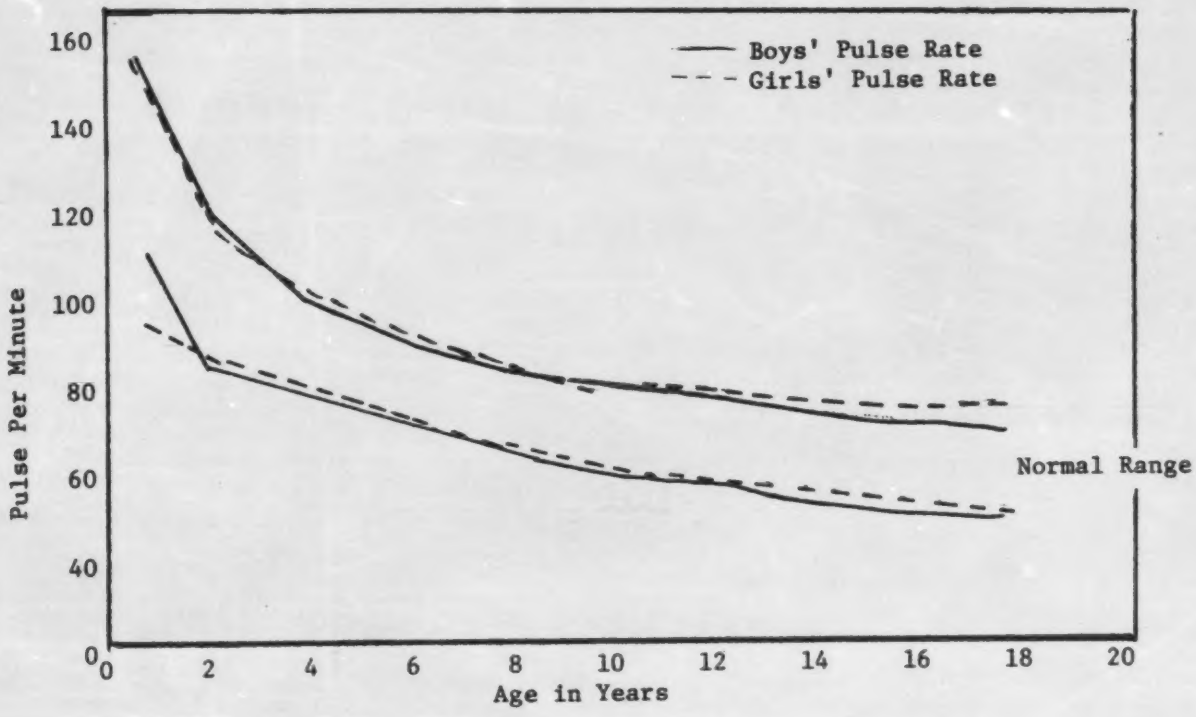
Definition: The periodic thrust felt over the arteries in time with the heart beat.

Procedure: (Apical pulse) Place stethoscope over the apex of the heart. Count the number of heart beats in one minute. Record the number. Be alert to abnormal rhythms and/or sounds, such as a murmur. Notify provider of findings.

Standards:

Age	Mean Heart Rate/min.
1 - 2 years	110 ± 40
2 - 4 years	105 ± 35
4 - 6 years	105 ± 35
6 - 12 years	95 ± 30
12 - 18 years	82 ± 25

PULSE RATES IN INFANTS AND CHILDREN



TEMPERATURE

Defintion: The measure of body heat, normally approximately 98.6° F.

Procedure: Electronic thermometer (e.g., Micronto)

Before starting to test children, turn the thermometer to "on" to check the battery charge. The needle should rise to 39° C to indicate the battery is adequate. Place a disposable cover on the probe, turn the indicator to "on". Position the probe under the child's tongue. It is not necessary for the child to close the mouth. Leave the probe in the month until the needle stops moving (about 30 seconds). Record the temperature in fahrenheit. Turn the indicator to "off". Dispose of cover.

Oral Thermometer

Remove from clean dispensor and make sure the mercury level is at 94°F or less. Insert the oral thermometer in the mouth with the mercury end under the tongue. Close the mouth and leave for three minutes. Remove and read the temperature. Record the number in Fahrenheit degrees. Shake down the thermometer and place into sterilizing solution. If covers are available, then omit the last item. If a child is too young to hold the thermometer in the mouth, have the thermometer held under the arm for five minutes.

Standards:

Age	Temperature in F.
3 months	99.4 $\pm$ 0.8
6 months	99.5 $\pm$ 0.6
1 year	99.7 $\pm$ 0.5
3 years	99.0 $\pm$ 0.5
5 years	98.6 $\pm$ 0.5
7 years	98.3 $\pm$ 0.5
9 years	98.1 $\pm$ 0.1
11 years	98.0 $\pm$ 0.5
13 years	97.8 $\pm$ 0.5

Axillary readings may be expected to be 0.5° F. lower than the oral readings.

URINALYSIS

Definition: A chemical examination of urine.

Procedure: A urine specimen is obtained in a numerically identified paper cup. A Uristix reagent strip is withdrawn from the container and dipped into the urine briefly to avoid dissolving out the reagents. The test results are read by a color comparison of the reagent strip to the identified standards, after waiting the indicated amount of time. The test results are recorded on to the physical examination form as neg. (negative), tr. (trace), +1 (plus one), +2 (plus two), etc. If the results of the Uristix test are plus one or greater for either albumen or glucose, or the student history gives reason to suspect a urinary tract abnormality then an additional strip is used to identify the presence of blood, acetone, pH, protein, glucose, ketones, and bilirubin. This information is then recorded on the physical examination form in the same manner as indicated above.

Standards:

Urinalysis (Albumen)	Negative	NA (no abnormality)
	Trace	NA (no abnormality)
	30	AB (abnormal)
	100	AB (abnormal)
	300	AB (abnormal)
	1000	AB (abnormal)
Urinalysis (Sugar)	Negative	NA (no abnormality)
	Trace 1/10	NA (no abnormality)
	1/4	AB (abnormal)
	1/2	AB (abnormal)
	1	AB (abnormal)
	2 or more	AB (abnormal)

BILI-LABSTIX®

REAGENT STRIPS FOR URINALYSIS

Dip-and-Read Test for pH, Protein, Glucose, Ketones, Bilirubin and Blood in Urine

SUMMARY AND EXPLANATION: BILI-LABSTIX® is a firm, plastic strip to which are affixed six separate reagent areas for testing for pH, protein, glucose, ketones, bilirubin and blood in urine. BILI-LABSTIX Reagent Strips are specifically designed for use in testing urine. Test results provide information regarding acid-base balance, the status of carbohydrate metabolism, and indications of kidney and liver function. The dry-reagent chemical technology in the six reagent test areas on BILI-LABSTIX has been progressively developed since 1956 and referred to in various publications.[1,2,3] Reactions in some instances are related to standard liquid reagent systems (such as the nitroprusside test for ketones and the "peroxidase" test for blood). In other instances (such as the colorimetric test for protein and the diazo test for bilirubin) the compositions are unique. The dip-and-read enzymatic test for glucose preceded the use of liquid enzyme systems for urine glucose.

The reagent test areas on BILI-LABSTIX are stable and ready to use on removal from the bottle. The entire reagent strip is disposable; no additional laboratory equipment is necessary for testing. The dip-and-read technique employed is easy to perform. However, as with all laboratory procedures, the test requires care in its performance. The directions must be followed exactly. Accurate timing is essential to provide reliable results. Some individuals may have difficulty in visually matching the color reactions to the Color Chart. The reagent strips must be kept in the bottle with the cap tightly closed (as specified on the cap) to maintain reagent reactivity. Also of great importance, any test result is no better than the specimen on which it is performed. Therefore, to obtain optimum results, it is necessary to use FRESH, *well-mixed*, uncentrifuged urine.

CHEMICAL PRINCIPLES OF PROCEDURES:

pH Test: This test is based on a double indicator principle which gives a broad range of colors covering the entire urinary pH range. Colors range from orange through yellow and green to blue.

Protein Test: This test is based on the protein error of indicators principle which means that at a constant buffered pH, any color development is due to the presence of protein. Colors range from green-yellow for "Negative" through yellow-green and green to green-blue for "Positive" reactions.

Glucose Test: This is a double sequential enzyme reaction. The reaction utilizes the enzyme glucose oxidase to catalyze the formation of gluconic acid and hydrogen peroxide from the oxidation of glucose. In turn, a second enzyme, peroxidase, catalyzes the reaction of hydrogen peroxide with a potassium iodide chromogen to oxidize the chromogen to a green to brown color.

Ketone Test: This reaction is based on the purple color developed with acetoacetic acid or acetone and nitroprusside. The components are stabilized in a dry reagent containing glycine as the nitrogen source and a strongly alkaline buffer.

Bilirubin Test: This reaction is based on the coupling of bilirubin with diazotized dichloroaniline in a strong acid medium. The color developed is a tan to purple shade.

Blood Test: The detection of occult blood is based on the peroxidase-like activity of hemoglobin which catalyzes the reaction of peroxide and the chromogen orthotolidine, to form blue oxidized orthotolidine.

REAGENTS: At the time of impregnation:

pH—0.14% w/w methyl red; 2.8% w/w bromthymol blue; 97% w/w non-reactive ingredients.

Protein—0.2% w/w tetrabromphenol blue; 99.8% w/w buffer.

Glucose—16.3% w/w glucose oxidase (1.3 I.U.); 0.6% w/w peroxidase (3300 I.U.); 7.0% w/w potassium iodide; 60.7% w/w buffer; 15.4% w/w non-reactive ingredients.

Ketones—1.1% w/w sodium nitroprusside; 36.1% w/w glycine; 57.8% w/w buffer; 5% w/w non-reactive ingredients.

Bilirubin—0.4% w/w 2, 4—dichloroaniline diazonium salt; 37.3% w/w buffer; 62.3% w/w non-reactive ingredients.

Blood—7.1% w/w cumene hydroperoxide; 0.6% w/w orthotolidine; 63.5% w/w buffer; 28.8% w/w non-reactive ingredients.

WARNINGS AND PRECAUTIONS: BILI-LABSTIX is intended for *in vitro* diagnostic use.

STORAGE: Store at temperatures under 30°C (86°F). Do not store in a refrigerator. Do not use after expiration date.

RECOMMENDED PROCEDURES FOR HANDLING BILI-LABSTIX: Do not touch test areas of the reagent strip. Keep reagent test areas away from detergents that may be found in specimen containers and other contaminating substances found in working areas. Do not remove desiccant from bottle. Replace cap immediately and tightly after removing reagent strip. Dip test areas in urine completely, but briefly, to avoid dissolving out reagents. Read test results carefully at the times specified, in a good light and with the test area held near the appropriate Color Chart on the bottle label. All unused strips must remain in the original bottle. Transfer to any other container may cause reagent strips to deteriorate and become unreactive.

IMPORTANT NOTE: PROTECTION AGAINST EXPOSURE TO LIGHT, HEAT AND MOISTURE IS MANDATORY TO GUARD AGAINST ALTERED REAGENT REACTIVITY. Deterioration may be noted by tan-to-brown discoloration or darkening of the reagent areas. If this is evident, or when test results are questionable or inconsistent with expected findings, the following steps are recommended: 1) Confirm that product is within expiration date shown on label. 2) Check performance against known positive control material (e.g., TEK-CHEK® Controls for Routine Urinalysis). If proper result is not obtained, discard and retest with fresh product.

(**NOTE:** As with all laboratory tests, definitive diagnostic or therapeutic decisions should not be based on any single result or method.)

SPECIMEN COLLECTION AND PREPARATION:

BILI-LABSTIX is designed to be used on any random (spot), freshly voided urine specimen, but also may be used on urines collected under special conditions, such as first morning specimens and postprandial urines. In all situations, the urine must be collected in a clean container and should be tested as soon as possible after collection. It is of particular importance to use fresh urine to obtain the best results with the test for urine bilirubin as this compound is very unstable when exposed only to room temperature and light. If testing cannot be performed within an hour after voiding, the specimen should be refrigerated immediately and returned to room temperature before testing. Urine, as any biological material, must be handled under strict sanitary conditions.

Prolonged exposure of unpreserved urine to room temperature may result in microbial contamination with resultant changes in pH. A shift to alkaline pH may cause false positive results with the protein test area. Urines containing glucose may decrease in pH as organisms utilize the glucose. Bacterial growth from contaminating organisms may cause positive blood reactions from peroxidases produced.

Preservatives do not prevent deterioration of urine ketones or bilirubin. (Some preservatives do not adequately protect the glucose which may be present from being metabolized by contaminating organisms—or those from bacterial infection.) The preservative, 8-hydroxyquinoline, may give false positive ketone reactions when used in excessive amounts. Urokeep and Kingsbury-Clark (Metropolitan Life Insurance Company) Urine Preservative Tablets do not give false positive results.

PROCEDURE: MUST BE FOLLOWED EXACTLY. While reagent strips are convenient to use, strict compliance with directions is required to achieve reliable test results.

1. Completely immerse all reagent areas of the strip in FRESH, *well-mixed*, uncentrifuged urine and remove immediately.
2. Tap edge of strip against the side of urine container to remove excess urine. **Hold the strip in a horizontal position to prevent possible mixing of chemicals from adjacent reagent areas and/or soiling of hands with urine.**
3. Compare test areas closely with corresponding Color Charts on the bottle label at the times specified. HOLD STRIP CLOSE TO COLOR BLOCKS AND MATCH CAREFULLY.

Certain colors continue to become more intense for a short time and then fade. pH and protein may be read at any time up to 1 minute after dipping. Glucose should be read at 10 seconds for qualitative results or at 30 seconds for quantitative results. The ketone test is read at 15 seconds, bilirubin at 20 seconds and blood at 30 seconds. The Color Chart is considered to be the "standard" for the colorimetric tests for urine incorporated in BILI-LABSTIX.

QUALITY CONTROL: For best results, quality control checks of reagents can readily be made each time a new bottle of reagents is opened by using a negative and a composite positive control as knowns. The negative gives confidence that no "false positives" are obtained and provides an appropriate negative reaction to make sure comparison to the "Negative" color blocks is being made properly. The positive control gives confidence that the reagents are reacting properly with positive specimens. In addition, a negative and a positive (preferably not the composite positive) should be hidden in each batch of urines tested throughout the day. TEK-CHEK® Controls for Routine Urinalysis, available from Ames Company, can be used for this purpose. These results plotted on the usual quality control chart provide evidence that the proper handling and testing procedures are being followed in the laboratory. Urinalysis is considered to be slipping out of control if a negative urine is called positive more than 5% of the time and/or if a positive reaction on any of the areas of the strip is called negative more than 5% of the time. Each laboratory should establish its own goals for adequate standards of performance. If continued unsatisfactory performance is obtained, the personnel involved may need further training, or closer supervision may be required.

RESULTS: Results with BILI-LABSTIX Reagent Strips are obtained in clinically valuable units directly from the Color Chart comparison. No calculations are required.

LIMITATIONS OF PROCEDURES: The limitations including interfering substances for each reagent area are shown below:

pH Test: If proper procedure is not followed and a drop of urine remains on the strip, it may wash the acid buffer from the neighboring protein reagent onto the pH area and change the pH reading to an acid pH if the urine being tested is originally neutral or alkaline. This is called the "run-over" phenomenon.

Protein Test: False positive results may be obtained with alkaline, highly buffered urines. Contaminating quaternary ammonium compounds may also give false positive results.

Glucose Test: Large amounts of ketone bodies (80 mg/dl or greater) may decrease color development. However it is unlikely that the presence of ketones simultaneously with glucose in the urine is sufficient to produce false negative results. At glucose levels of 1 g/dl or greater, the color may appear somewhat mottled. The darkest color should be used in interpreting results with the Color Chart.

Ketone Test: Color reactions that could be interpreted as "Positive" may be obtained with urine specimens containing bromsulphalein or by large amounts of phenylketones or L-Dopa metabolites.

Bilirubin Test: Since very small amounts of bilirubin may be found in the earliest phases of liver disease, *the user must consider whether the sensitivity of BILI-LABSTIX to bilirubin is sufficient for the intended use.* When very small amounts of bilirubin in urine are sought (e.g., earliest phase of viral hepatitis) ICTOTEST® Reagent Tablets should be the method of choice. Reactions may occur with urine specimens from patients receiving large doses of chlorpromazine which might be mistaken for positive bilirubin. Metabolites of drugs which give a color at low pH, such as Pyridium and Serenium, may give a red or other color to this test area.

Blood Test: The sensitivity of the blood test is reduced in urines with high specific gravity and/or high ascorbic acid content. Certain oxidizing contaminants such as hypochlorite may produce false positive results. Microbial peroxidase, associated with urinary tract infection, may cause a false positive reaction.

EXPECTED VALUES: Expected values for the typical "normal" healthy population as well as the abnormal population are listed below for each reagent:

pH Test: Both the normal and abnormal urinary pH range is from 5 to 9.

Protein Test: Normally no detectable protein is present in urine although there is a minute amount excreted by the normal kidney. A color matching any block marked with + signs indicates significant proteinuria. Clinical judgment must determine the significance of "Trace" results. Particularly in urines of high specific gravity, the test area may most closely match "Trace" despite only physiological concentrations of protein.

Glucose Test: Normally no detectable glucose is present in urine. Concentrations of as little as 0.1 g/dl glucose, read either at 10 or 30 seconds, may be significantly abnormal if found consistently. At 10 seconds, results should be interpreted qualitatively; i.e., negative or positive. For quantitation, read at 30 seconds only.

Ketone Test: Normally no ketones are present in urine. In starvation diets, or in other abnormal carbohydrate metabolism situations, ketones appear in the urine in excessively large amounts before serum ketones are elevated.

Bilirubin Test: Normally no bilirubin is detectable in urine by even the most sensitive methods. Even trace amounts of bilirubin are sufficiently abnormal to require further investigation. Atypical colors (colors produced which are different than the negative or positive color blocks shown on the Color Chart) may indicate that bilirubin derived bile pigments are present in the urine sample and are possibly masking the bilirubin reaction. These reactions may indicate bile pigment abnormalities and in such incidences the urine specimen should be tested further (e.g., ICTOTEST).

Blood Test: Any blue spots or blue color developing on the reagent area within 30 seconds is significant and the urine should be examined further. Blood is frequently, but not invariably, found in the urine of menstruating females. The blood test on BILI-LABSTIX is highly sensitive to hemoglobin (it is slightly less so to intact erythrocytes) and thus complements the microscopic examination.

SPECIFIC PERFORMANCE CHARACTERISTICS:

pH Test: The pH test area permits quantitative differentiation of pH values to one unit within the range of 5-9. pH readings are not affected by variations in the urinary buffer concentration.

Protein Test: Quantitative results are obtained from this test area. Five to 20 mg of albumin per dl urine may be detected as a "Trace" result. The test area is more sensitive to albumin than to globulin, hemoglobin, Bence-Jones protein and mucoprotein; a negative result, therefore, does not rule out the presence of these other proteins.

Glucose Test: This reagent test area may be read at 10 seconds for qualitative results or 30 seconds for quantitative results. The test is specific for glucose; no substance excreted in urine other than glucose is known to give a positive result. The reagent area does not react with lactose, galactose, fructose nor reducing metabolites of drugs; e.g., salicylates and nalidixic acid. This test may be used to determine whether the reducing substance found in urine is glucose. Approximately 0.1 g of glucose per dl of urine is detectable. Reactivity may be influenced by specific gravity and temperatures of urine. The test is more sensitive than the copper reduction test, CLINITEST® Reagent Tablets. Unlike other glucose oxidase tests, this glucose test shows negligible inhibition by ascorbic acid.

Ketone Test: The ketone test area provides semi-quantitative results (small, moderate and large) and reacts with aceto-acetic acid and acetone in urine. It does not react with beta-hydroxybutyric acid. The reagent area detects as little as 5 to 10 mg acetoacetic acid per dl urine. It is less sensitive to acetone.

Bilirubin Test: The test has a sensitivity of 0.2-0.4 mg bilirubin/dl (Golden & Snavely Procedure).[3] In comparison to ICTOTEST, it is 2 to 4 times less sensitive. The test is considered specific for bilirubin in urine.

Blood Test: At the time of reagent manufacture, the test when read as instructed has a sensitivity to free hemoglobin of 0.015 mg/dl or 5 intact red blood cells/µl in urines with a specific gravity of 1.005 and ascorbic acid concentrations of less than 5 mg/dl. The sensitivity may be expected to be less in urines with high specific gravity and ascorbic acid content. The test is slightly more sensitive to free hemoglobin and myoglobin than to intact erythrocytes.

AVAILABILITY: BILI-LABSTIX is available in bottles of 100 strips (2814).

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AMES COMPANY®, Division Miles Laboratories, Inc., Elkhart, Indiana 46514

VISION

Definition: Ocular perception.

Procedure: Vision screening is normally one aspect of a school's health program. By state code school age children are to receive vision screening in grades 1, 3, 5, and 10. The nature of migrancy precludes regular participation in this program, so additional screening dates are normally provided for migrant children during impaction times. Note: State code requires that, "all new students in a district regardless of grade level, shall be screened as soon as possible after admission."

Vision screening is a three-step process: observation, testing, and where necessary referral. The "A B C " (Appearance, Behavior, and Complaints) approach by teachers, aides, and nurses (see attached) will catch many potential problems and provide a basis for referral.

The formalized screening most commonly used is the Snellen chart with the 20 feet distance test of each eye and both eyes together. The data is reported by vision and feet. 20/20 is the accepted norm for satisfactory vision for age five and up. Any test result progressing beyond 20/40 should be referred to the family as a need for further testing. (WAC 248-148-180)

The Snellen test is considered a gross measure of vision and there is some question as to whether it should be utilized in schools. However, lack of equipment and staff precludes requiring another vision test. However, it is recommended that a binocular screening device be used (e.g., Titmus Vision Tester) whenever possible.

Standards:		
	Age 1	20/100
	Age 2	20/40
	Age 3	20/30
	Age 4	20/20 - 10
	Age 5	20/20
	Age 6	20/20 Central acuity is unconditionally established.

Referrals should be made for visual acuity scores progressing beyond 20/40 or less.

VISION SCREENING A B C s

APPEARANCE, BEHAVIOR, COMPLAINTS

The following are the ABC symptoms which may indicate a vision problem, regardless of results on any screening test:

APPEARANCE OF THE EYES

Eyes crossed – turning in or out – at any time.
Reddened eyes.
Watering eyes.
Encrusted eyelids.
Frequent styes.

BEHAVIOR INDICATIONS OF POSSIBLE VISION DIFFICULTY

Body rigidity while looking at distant objects.
Thrusting head forward or backward while looking at distant objects.
Avoiding close work.
Short attention span.
Daydreaming.
Turning of head so as to use one eye only.
Tilting head to one side.
Placing head close to book or desk when reading or writing.
Frowning or scowling while reading or writing.
Excessive blinking.
Tending to rub eyes.
Closing or covering one eye.
Dislike for tasks requiring sustained visual concentration.
Nervousness, irritability or restlessness after maintaining visual concentration.
Unusual fatigue after completing a vision task.
Losing place while reading.
Using finger or a marker to guide eyes.
Saying words aloud or lip reading.
Moving head rather than the eyes while reading.
Difficulty in remembering what is read.
Persistent reversals after the second grade.
Confusion of similar words.
Poor eye-hand coordination.
Unusual awkwardness.

COMPLAINTS ASSOCIATED WITH USING THE EYES

Headaches.
Nausea.
Burning or itching of eyes.
Blurring of vision at any time.

STANDARDS AND PROCEDURES FOR TUBERCULIN TESTING

Mantoux Method, using tuberculin purified protein derivative, diluted stabilized solution (Aplisol-Parke Davis).

I. GENERAL:

Tuberculin-PPD is a major aid in detection of infection with tuberculosis. The diluted sequence solution of purified protein fraction is derived from culture filtrants of human type strains of Myco-bacterium tuberculosis by the method of Florence Siebert and is known as PPD-S and serves as the international standard, 0.1 ml of the diluted product being equivelent of 0.0001 mg or intermediate strength or 5 TU, and is considered the standard tuberculin test.

Reactions to the controlled intradermal injection of 0.1 ml of the product are read at 48-72 hours by quantitative measurement of the diameter of induration (swelling or thickening) in the transverse axis of the arm and recorded in millimeters. Erythema (redness) alone may be disregarded if less than 10 mm in the absence of induration, but may indicate necessity of retesting if greater than 10 mm. Induration of 10 mm or more is considered positive, or 5-9 mm doubtful, and less than 5 mm negative.

Testing should not be performed if there is an obvious pre-existing condition or disease state of an arm such as lymphodema (swelling) such as occurs in some mastectomy patients.

II. EQUIPMENT AND REAGENTS:

A. Aplisol (Parks Davis) Tuberculin PPD or comparable PPD is recommended.

B. 1.0 ml syringe (tuberculin) with beveled 26 or 27 gauge needle.

III. TECHNIQUE:

A. The site of the test is usually the flexor or volar (hairless) surface of the forearm about 4" below the elbow. Other skin sites may be used, but the flexor surface of the forearm is preferred.

B. The skin at the injection site is cleansed with soap and water and allowed to dry.

C. The test material is administered with a tuberculin syringe (1.0 ml) fitted with a short (1/2") 26 or 27 gauge needle.

D. The syringe and needle should be of a sterile disposable, single use type or should have been sterilized by authoclaving, boiling, or by the use of dry heat. A separate sterile unit should be used for each person tested.

E. The diaphragm of the vial-stopper should be wiped with 70% alcohol.

F. The needle is inserted through the stopper diaphragm or the inverted vial. Exactly 0.1 ml is filled into the syringe with care being taken to exclude air bubbles and to maintain the lumen of the needle filled.

G. The point of the needle is inserted into the most superficial layers of the skin with the needle bevel pointing upward. As the tuberculin solution is injected, a pale bleb 6-10 mm in size (3/8") will rise over the point of the needle. This is quickly absorbed and no dressing is required.

In the event the injection is delivered subcutaneously (i.e., no bleb will form) or if a significant part of the dose leaks from the injection site, the test should be repeated immediately at another injection site at least 5 cm (2") removed.

If a drop of blood appears at the injection site, it indicates the injection may not be intradermal, but may have been deep dermal or subcutaneous. Although some authorities accept a bloody injection as long as a wheal or bleb is formed, it is best to allow a reading if a bleb is formed, but repeat injection if injection if negative or doubtful.

IV. Reading:

A. The result of the test is read once 48 - 72 hours after injection. Induration (swelling or thickness) is measured transversely to the long axis of the forearm and recorded in millimeters. Erythema (redness) alone may be disregarded if less than 10 mm, but may indicate the injection was too deep. If over 10 mm, the test should be repeated.

V. Interpretation:

A. Positive: Record with induration diameter in mm in parenthesis; e.g., positive (5 or greater mm). This indicates past or present infection with M.

tuberculosis.

B. Negative: 0-4 mm induration. Indicates a lack of hypersensitivity to tubercultin and tuberculous infection is unlikely. If under age 20 - retest if any induration.

VI. RECORD RESULTS AS FOLLOWS:

Intradermal Mantoux 5 TU PPD-S (good wheal)

Positive: _____ mm induration

or Negative: _____ mm induration

Redness may be noted as a non-specific reaction, but only induration is significant.

Where positive readings have been determined, referral shall be made to the local health department.

VII. COMMENTS:

A. The intradermal Mantoux test may be used in children in preference to the Tine test which generally delivers more than 5 TU of antigen into the skin and is utilized for mass screenings.

B. Allergic reactions are rare. Patients who claim allergy should be referred to the pathologist or patient's physician.

C. Reaction to tuberculin may be suppressed as long as 4 weeks after viral infections, live virus vaccines (measles, smallpox, polio, rubella, and mumps) or be administration of corticosteroids. Malnutrition, acute illness, advanced age may also be suppressive.

D. Non-reactive patients can be tested at any interval, but are generally tested every year (or six months). Frequent examination of non-reactors may be precipitated by epidemiologic survey caused by an active case exposure.

E. Repeated testing of the unifected individual does not sensitize to tuberculin. In patients with waning sensitivity, the stimulus of a tuberculin test may boost or increase the size of the reaction to a second test.

F. Various atypical mycobacterial infections may give a sensitivity to tuberculin and a doubtful reaction. Dual testing using PPD-B (Battery), a derivative of a Group III Strain may help distinguish tuberculin sensitivity caused by another (non-tuberculosis) mycobacterium.

G. There is some controversy over the use of 70% alcohol in skin antisepsis in that residual or incomplete evaporation may denature PPD protein. Therefore, clease the skin with soap and water. The skin surface should be allowed to dry before injection or wiped dry.

H. False negatives in known tuberculosis may approximate 17%, negative reactions associated with advanced or disseminated disease, old age, or debility.

I. Before considering conversion from negative to positive, it is important to ascertain that the patient has been tested by the Tween-80 product such as Aplisol. Negative reactions with reconstituted products occur in a very high percentage of people tested.

J. In patients whom have been immunized with BCG, tuberculin reactivity wans rather rapidly in the year after innoculation. Although, each case must be individualized, BCG immunization is not considered a contraindication to tuberculin testing. While testing with 5 TU of PPD may be equivocal, use of 1 TU will demonstrate tuberculin reactivity to tuberculosis while BCG vaccinated individuals without tuberculosis will be negative.

IMMUNIZATIONS

Effective September 1, 1979, all children enrolled in day-care centers, pre-school programs and in kindergarten through sixth grade must present proof of adequate immunization levels for the following vaccine-preventable diseases: diphtheria, whooping cough, lockjaw, polio, measles, rubella and mumps. In September 1980, students in grades seven through twelve will also be subject to the new immunization law.

If a child's protection level is not adequate, there will be 45 calendar days from the date of enrollment in which to submit proof of required immunization to the school. A student not meeting these requirements will be excluded from school. A child may be exempted for religious, philosophical or medical reasons as defined by the law.

Following are the immunization requirements:

1. At least three doses of DTP, DT or Td vaccine, provided the last dose was administered at or after the age of four.
2. At least three doses of oral or injectable trivalent poliomyeltis vaccine, provided the last dose was administered at or after the age of four.
3. One dose of live-virus measles vaccine administered at or after the age of one. (An individual meets the measles immunization requirement as a result of having had 10-day rubeola measles. In such instances, a physican must document and certify the month and year of disease occurrance.)
4. One dose of live-virus rubella vaccine administered at or after the age of one. (Vaccination for girls 12 and older is not recommended, however, except by authorization of a physician.
5. One dose of live-virus mumps vaccine administered at or after the age of one for children in kindergarten or first grade, whichever is the school entry level. (Mumps vaccination for children beyond these age levels are not required under the law.)

The MSRTS record is an official academic and medical record approved under ESEA Title I, Migrant and has been approved by DSHS as an acceptable record for proof of immunization.

The responsibility for the immunization program (notification and provision for administration of vaccines) falls on the health department and the schools. Migrant education may be a resource to establish linkage to available health care delivery systems. In the absence of immunization services, migrant education can provide the service through negotiated agreement.

Refer to WAC 248-100-163.

SCOLIOSIS

Effective September 1, 1979 a new state law requires an annual public school scoliosis screening program for children in grades 5 through 8, although children may be exempted by parental request.

Scoliosis is a lateral curvature and rotation of the spine that occurs most frequently in the 10-to-16 age group. If not recognized and treated, scoliosis can develop into a permanent crippling disability.

Refer to SHB88.

EMERGENCY HEALTH SERVICES POLICY

Emergency health needs are defined as those needs that a student has in the area of health when a student cannot attend school or learn because of a health problem. For example: a toothache, an earache, or complications of a health problem such as an earache as a result of enlarged or infected tonsils.

When a health referral mechanism is established (e.g., Rural Health Clinic) the student will be referred by school personnel and/or parents directly to the appropriate agency.

Where no health mechanism exists then local resources are to be explored and utilized where possible. When such resources are exhausted then Emergency Health Service dollars may be requested.

The process for providing emergency health funds for migrant students is:

1. the need of the student must be determined by the appropriate school person to be an emergency.
2. all other resources must be exhausted before using the migrant education emergency money (e.g., health clinics, county hospital, service clubs, etc.).
3. The LEAs procedures for referral and payment are to be followed.

The Emergency Medical Referral form may be used as an auditable record by the school.

8/79

EMERGENCY MEDICAL REFERRAL FORM

SCHOOL DISTRICT: _____

DATE: _____

REFERRED BY: _____
Name and Title

_____ has been referred
(Child's name)

to _____ for
(Agency name)

_____
(Condition(s)

It is further understood that the _____ school district is not responsible or liable for any fees that are incurred as a result of this referral.

MIGRANT EDUCATION PROGRAM CLAIM FORM

It is necessary to file just one completed claim form for each accident. If more than one doctor is involved in the treatment or if there are bills for hospital or ambulance attach the additional bills to this report. No bills can be processed until this completed claim form has been submitted.

This part to be completed by **SCHOOL**

Student's Name _____ (last name) _____ (first name) _____ (initial) Grade _____

Address _____ (number) _____ (town) _____ (state) _____ (zip code)

Name of School _____ Name of District _____

Did school personnel know of the accident at the time it happened?

☐ YES Date of Accident _____ (month, day, year) Time _____ Place _____

How did the accident happen and what was the injury? _____

_____

For more details contact _____ (supervisor, teacher or other authority)

☐ NO Please give reason; for example, the accident wasn't at school or was not reported when it happened, etc. _____

_____

Signature X _____ (school official) Title _____ Date _____

PARA LOS PADRES O LOS GUARDIANES

Fecha del accidente _____ mes día año

Hora del accidente _____

Lugar del accidente _____

¿ Cómo ocurrió el accidente y cuál fue el daño? _____

_____

¿ Tiene otros seguros, un plan de salud o ayuda del estado?
☐ Sí ☐ No

Nombre de la compañía de seguros _____

_____

Número de la póliza de seguros _____

Dirección de la otra compañía de seguros _____

_____

Nombres del hospital y/o los médicos quienes tratan esta daño

_____

Yo afirmo que la información incluída arriba esté correcta y autorizo el uso de la información médica para el procedimiento de esta petición.

_____
Firma del padre (o madre) o del guardian Fecha

To be completed by **PARENT OR GUARDIAN**

Date of Accident _____ (month , day , year)

Time _____

Place _____

How did the accident happen and what was the injury?

_____

Do you have other insurance, a health plan or state assistance?
☐ Yes ☐ No

Name _____

Policy Identification No. _____

Address of other plan _____

Names of hospital and/or doctors providing medical care for this injury:

_____

_____

I certify the foregoing information is correct and authorize the release of any medical information necessary to process this claim.

_____
Signature of parent or guardian Date

HEALTH INSURANCE CLAIM FORM

Type or Print

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1- Patient's Name (First Name, Middle Initial, Last Name)	2- Patient's Sex

PHYSICIAN OR SUPPLIER INFORMATION

3- Date Illness / Injury / Pregnancy — Date of first symptoms / Date of accident / Date of LMP	4- Date first consulted you for this condition	5- Has patient ever had same or similar symptoms? ☐ No ☐ Yes

6- Date patient should be able to return to work	7- Dates of Patient's Disability From (date)	Total disability through (date)	From (date)	Partial disability through

8- Name of referring physician	9- For services related to hospitalization, give hospitalization dates	Date Admitted	Date Discharged

10- Name & Address of facility where services rendered (if other than home or office)

11- Diagnosis or nature of illness or injury requiring services or supplies (relate diagnosis to procedure by reference to numbers 1, 2, 3, etc. in column D).

A Date of Each Service	B Place of Service *See Codes below	C Describe surgical or medical procedures and other services or supplies for each date given — Procedure Code	(Explain Unusual Services)	D DX No.	E Charges (Explain Unusual circumstances in Column C)		F Leave Blank

13- Physician's or supplier's name, address, zip code & telephone no.	14- Social Security No.	15- Total Charges	
	16- Employer I.D. No.	17- Amount Paid	By Whom
	18- Other Identifying No.	19- Balance Due	

20- Accept Assignment ☐ Yes ☐ No	21- Signature of Physician or Supplier Sign Here	22- Date Signed	23- Your Patient's Account No.

24- If patient has other health insurance, health plan or state assistance, enter its name, address & policy or Medical Assistance Number

PLACE OF SERVICE CODES

1- (IH) - Inpatient Hospital
2- (OH)- Outpatient Hospital
2- (O) - Doctor's Office
4 - (H) - Patient's Home
5 - (PSY) - Day Care Facility
6 - (PSY) - Night Care Facility
7 - (NH) - Nursing Home
8 - (SNF) - Skilled Nursing Facility
9 - Ambulance
O - (OL) - Other Locations
A - (IL) - Independent Laboratory
B - Other Medical Surgical Facility

EMPIRE INSURANCE AGENCY, INC.
226 SECOND AVENUE W.
SEATTLE, WASHINGTON 98119

A Parent's Guide to Migrant Education Accident Insurance

Migrant Education Program Accident Insurance

Who is Covered?

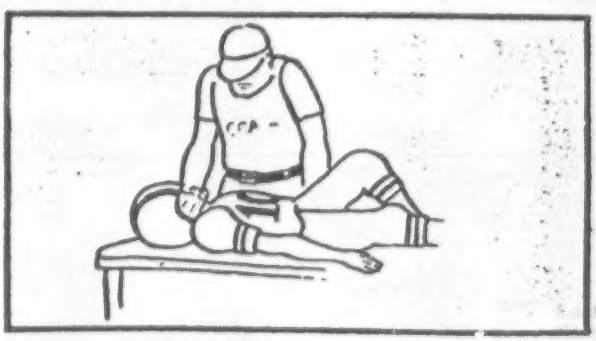
Each migrant child enrolled in the Migrant Student Record Transfer System (MSRTS) in Washington State is covered by accident insurance. The insurance costs nothing to the child's family, and it will pay the full cost of most medical bills resulting from a child's accident.

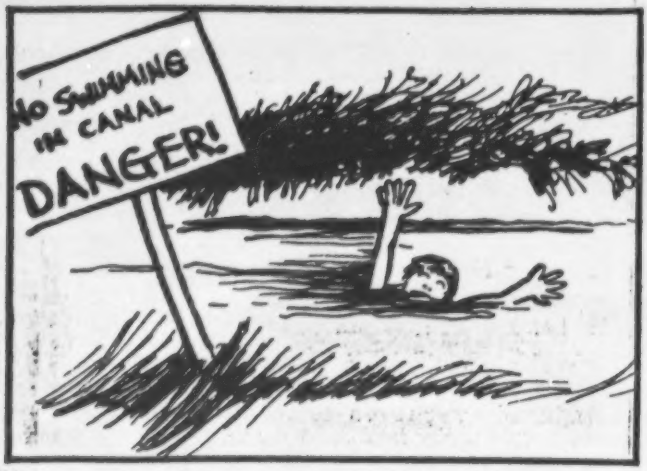
Coverage begins once the child is enrolled in the MSRTS and continues through the next August 31, as long as the child remains in Washington State.

What is Covered?

The insurance covers accidents that occur at home or at school, 24 hours a day, seven days a week.

Almost all accidental injuries are covered, including accidents that happen from interscholastic sports. It





does not cover automobile accidents unless the vehicle was being used, at the time of the accident, for transportation to or from school or for a school activity, such as a field trip. Motorcycle accidents are not covered.

How Much Does it Pay?

The insurance pays for all medical costs up to $5,000 per accident. This includes dental work, ambulance service, and drugs prescribed because of the accident. Routine medical and dental check-ups are not covered. Medical or dental care due to illness is not covered unless the illness is caused by an accidental injury.

Death caused by accidental injury is covered for $1,000.

Dismemberment -- loss of limbs or sight -- pays up to $5,000, depending upon the extent of the injury.

Remember These Important Things About Insurance Program Eligibility

- To qualify for Migrant Education Program Accident Insurance, a child must move across school district boundaries in order that a member of his immediate family might secure temporary or seasonal work in agriculture, fisheries or related industries. A child whose family has ceased to migrate remains eligible for the insurance for five years, as long as he is annually enrolled in the MSRTS.

- Children age 0 to 2 are not eligible for the MSRTS. However, they are covered by Migrant Education Program Accident Insurance if they attend a Title I Migrant day care program.

- Even though you may withdraw your child from school or approved day care facility, he or she will continue to be covered by the insurance until the next August 31, unless your family moves to another state.

- If you enroll your child in a school district not implementing the MSRTS, insist the school district look into the possibility of becoming part of the MSRTS by contacting:
  State MSRTS Office
  701 North Avenue
  Sunnyside, Washington 98944
  (509) 837-2712

Follow These Steps to Protect Yourself From the Medical Costs of Your Child's Accidental Injury

1. Upon enrolling your child in a school having the MSRTS, insist he or she be placed in the MSRTS immediately. The insurance does not take effect until the child's enrollment has been received at an MSRTS terminal, regardless how long he or she has been in school.

2. If your child is injured, contact your school district office, migrant home visitor, or if your child is not currently enrolled in school, your MEIRP field representative. Someone will help you to fill out a claim form which you must take to the doctor or hospital for signatures. You are responsible for sending the completed form to the insurance company. A claim must be filed within 90 days of the injury. Additional medical bills for the same injury do not require a second claim form and may be sent directly to the insurance company. Bills that are not covered by the insurance will be returned to you.

3. Any questions you have about a particular claim that the school can't answer should be directed to the migrant insurance adjuster at:

Empire Insurance Agency
226 Second Avenue West
Seattle, Washington 98119
1-800-562-2862 (Toll Free)

FOR MORE INFORMATION, CONTACT:

Empire Insurance Agency
226 Second Avenue West
Seattle, Washington 98119
1-800-562-2862 (Toll Free)

The Migrant Student
Record Transfer System
Ignacio "Joe" Resendez
Supervisor
701 North Avenue
Sunnyside, Washington 98944
(509) 837-2712

Washington State Migrant Education
Dr. Frank B. Brouillet, Superintendent of Public Instruction. Funded under P.L. 93-380, ESEA Title I Migrant.

Questions About the Accident Insurance Program

Q: Does the accident insurance cover a tonsillectomy or other surgery?
A: No. Only when the surgery is due to an accident.

Q: Is a migrant student covered for accidents while committing a crime? What about alcohol, drugs or fights?
A: No. If, for example, a student cuts his hand while breaking through a store window, he is not covered. If the student is accidentally injured while under the influence of alcohol or drugs, he is not covered. A student is not covered for injuries received from a fight.

Q: If a child is injured by a gunshot wound, is he covered?
A: Yes. As long as the injury is caused from an accident, for example while hunting. A gunshot wound from a fight is not covered.

Q: My child was injured in another state while we were on our way to Washington State to work. Is he covered?
A: No. Only a few states provide insurance for migrant students even though all states implement the MSRTS and other migrant programs. The Migrant Education Program Accident Insurance provided by Washington State covers only those accidental injuries which happen while a student resides here.

Q: What is included in the term dismemberment?
A: Loss of both hands, loss of both feet, loss of sight in both eyes or any combination thereof is covered for $5,000. Loss of one hand, loss of one foot or loss of sight in one eye is covered for $1,000. The loss must result within 90 days of the injury.

Q: Does the parent receive a copy of the insurance policy?
A: No. The school has the policy.

Q: What if my child is injured during the summer and there is no one at the school to help me file a claim?
A: You will have to do it yourself. Claim forms are available from Empire Insurance Company, whose address is listed in this pamphlet. Claim forms and assistance are available also from the MSRTS office, whose address is also listed in this pamphlet.

STUDENT HEALTH NOTICE

8/79

STUDENT'S NAME / NOMBRE DEL ESTUDIANTE _____

Dear Parents:

Health examinations will be held at our school very soon. Your child will be receiving a physical examination by _____.
The physical examination is provided free of charge. Please sign this form and complete the information below for your child. This information is important as it will help us develop a permanent health record on your child.
After completing the following information, please return it to the school with your child. You will be receiving a copy of the physical examination form and its results from the school or clinic.

Your cooperation and promptness is greatly appreciated.

Estimados Padres:

Nuestra escuela va a estar dando examenes de salud. Su niño(a) recibirá un examen físico por _____ _____. El examen físico es gratis. Firme esta forma y complete la información requerida para su niño(a). Esta información es importante porque nos ayudará a hacer un archivo de salud permanente que le siguirá a su niño(a) mientras termine su educación.

Al completar la información requerida, háganos el favor de mandar esta forma a la escuela con su niño(a). Usted recibirá una copia de los resultados del examen físico de la escuela o la clínica.

Le agradecemos su cooperación y puntualidad.

CHILD'S HISTORY (Check if Child has had)
HISTORIA DE SALUD DE SU NINO(A) (Marque si su Niño(a) ha tenido las siguientes)

Physical Handicap/Impedimento físico _____
Measles/Sarampíon _____
Rubella/Rúbeola _____
Diabetes/Diabetes _____
Mumps/Papera _____
Chicken Pox/Viruela _____
Whooping Cough/Tos Ferina _____
Other/Otro _____
Indicate Allergies/Indique Alergias _____
Medication presently in use/Indique que medicina su nino)a) esta tomando: _____

IMMEDIATE FAMILY HISTORY (Check those applicable)
HISTORIA DE SU FAMILIA INMEDIATA (Marque las siguientes que han tenido)

Cancer/Cáncer _____
Convulsions/Convulsiones _____
Diabetes/Diabetes _____
Heart Disease/Enfermedad del Corazón _____
High Blood Pressure/Alta presión _____
Kidney Disease/ Enfermedades de los Riñones _____
Allergies/Alergias _____
Other/Otra _____

BIRTH HISTORY (Child's)
HISTORIA DE NACIMIENTO (De su Niño(a))

	(Check/Marque) Normal/Normal	(Indicate/Indique) Abnormal/Anormal
Pregnancy/Embarazo	_____	_____
Delivery/El Parto	_____	_____
New Born/Recién nacido	_____	_____

PREVIOUS TUBERCULIN SKIN TEST RESULT (Check only if previously received) **Positive** _____ **Negative** _____
Date Given _____ **Have you received treatment for tuberculosis?** **YES**_____ **NO** _____

RESULTADO ANTERIOR DEL EXAMEN DE TUBERCULINA (Marque solamente si lo ha recibido previamente) Positivo ___ Negativo ___
Fecha que la dierol _____¿Ha recibido tratamiento para Tuberculosis? Si ___ No ___

84

_____
Parent's or Guardian's Signature/Firma de los Padres o Encargados **Date**/Fecha

WRITE FIRMLY

WASHINGTON STATE
MIGRANT STUDENT MEDICAL RECORD

8/79

STUDENT DESCRIPTION

Last Name	First Name	Sex	Birthday Month	Day	Year	Student Number	MNE
						Migrant Status	

Current Address	School and District or Agency
Home Base Address	Place of Birth

CHILD'S HISTORY

Physical handicap ___ Measles ___ Rubella ___ Mumps ___
Chicken Pox ___ Whooping Cough ___ Diabetes ___
Other _____
Allergies _____
Medications presently taking _____
PREVIOUS TB SKIN TEST RESULT: Check
Positive ___ Negative ___ Date Given _____
Have you received treatment for tuberculosis? Yes ___ No ___

PRELIMINARY ASSESSMENT

B.P. ___
Pulse ___
Temp. ___

Vision
R20/ ___
L20/ ___
GL R20/ ___
GL L20/ ___

Hearing
R ___
L ___

Color Vision
Normal ___ Abnormal ___

Ht. ___
Wt. ___

TB (PPD) SKIN TEST Date Given _____
RESULTS (Indicate in mm.) Positive ___ Negative ___

_____ _____
Signature and Title Date

BIRTH HISTORY

	Normal	Abnormal
Pregnancy		
Delivery		
New Born		

IMMEDIATE FAMILY HISTORY

Check if there is any history in the family of the following:
Allergies _____
Cancer ___ Heart Disease ___
Convulsions ___ High Blood Pressure ___
Diabetes ___ Kidney Disease ___
Other _____

LAB TEST RESULTS

Urinalysis	Not Done	Albumen ___	Sugar ___
Bilirubin ___	pH ___	Ketones ___	Blood ___
Parasitic Screen	Not Done	Positive ___	Negative ___
Lead Screen	Not Done	Positive ___	Negative ___
Sickle Test	Not Done	Positive ___	Negative ___
Hematocrit (HCT)	Not Done		%

PHYSICAL EXAMINATION

	Appears Normal	Appears Abnormal	Not Examined
General appearance, posture			
Gait			
Speech			
Skin			
Eyes: External			
Optic Fundi			
Ears: External and Canals			
Tympanic Membranes			
Nose, mouth, pharynx			
Teeth			
Heart			
Kidneys			
Lungs			
Abdomen (include hernias)			
Genitalia			
Bones, joints, muscles, scoliosis			
Neurologic exam			
Rectal			
Pelvic			
Other			
DEVELOPMENTAL SCREENING			
Gross motor function			
Fine motor and manipulative functions			
Adaptive function			
Language function			
Personal-social function			

DEAR PARENT

Your child was found to be in satisfactory health:
Yes ___ No ___

Referral Recommended: Yes ___ No ___
Prescribed Medications: Yes ___ No ___

Exam Site: (Circle) School Clinic Van

_____ _____
Examiner's Signature Exam Date

White copy – Migrant Education
Pink copy – School
Yellow copy – Parent
Blue copy – Clinic

STATE OF WASHINGTON
SUPERINTENDENT OF PUBLIC INSTRUCTION
MIGRANT EDUCATION PROGRAM

SPI

Certificate of Pupil Eligibility

County _____ School District _____ School Year ____ - ____

FOR OFFICE USE ONLY
DATE REC'D _____
DATE CHECKED _____
DATE RETURNED _____
MSRTS ☐ MEIRP ☐

☐ Pre-school
☐ Regular
☐ Summer
☐ _____

NAMES OF CHILDREN/NOMBRES DE LOS NINOS

LAST NAME/APELLIDO PATERNO	FIRST NAME/PRIMER NOMBRE	MI	SEX	BIRTHDATE MO. - DA. - YR.	V	GRADE	CITY OF BIRTH/ CIUDAD DE NACIMIENTO	STATE/COUNTRY OF BIRTH ESTADO/PAIS DE NACIMIENTO

LAST SCHOOL ATTENDED | CITY | STATE

CURRENT RESIDENCE – DOMICILIO PRESENTE | LEGAL GUARDIAN/PARENT DATA/NOMBRES DE PADRES

STREET ADDRESS | LAST NAME | FIRST NAME

ST. ZIP PHONE

V... MIGRATORY STATUS
☐INTERSTATE ☐FORMERLY
☐INTRASTATE MIGRATORY

INDUSTRY
☐AGRICULTURE ☐COMMERCIAL
☐HORTICULTURE FISHING

ETHNIC BREAKDOWN
☐MEXICAN-AMERICAN ☐NATIVE-AMERICAN ☐OTHER_____
☐ANGLO-AMERICAN ☐AFRO-AMERICAN

...PREVIOUSLY MIGRATED TO ... PREVIOUSLY? ☐YES ☐NO

DO YOU HAVE FURTHER PLANS OF MIGRATING? ☐YES ☐NO

IF SO, WHERE?
☐COLUMBIA BASIN
☐YAKIMA VALLEY
☐WALLA WALLA/COLUMBIA
☐CHELAN/OKANAGAN
☐SKAGIT/WHATCOM
☐OTHER _____

V... ...MAILING ADDRESS IF DIFFERENT AT OF ARRIBA | CARE/DIRECTION | PUEBLO | ESTADO | ZIP

HOME BASE ADDRESS

...MAILING ADDRESS IF DIFFERENT FROM ABOVE | STREET | CITY | STATE | ZIP

Yo certifico que los nombres de los niños escritos en esta forma se movieron conmigo de _____ para _____, WA en (fecha) _____, 19_____, mientras nosotros estabamos empleados o buscando empleo en trabajo de agricultura, horticultura, pesca comercial o actividades relacionadas como empacadoras y bodegas de verduras o actividades de procesar comida. Mis niños tienen mi permiso para participar en los programas designados para confrontar las necesidades de niños de trabajadores migratorios. Además doy mi permiso para que mis niños reciban un examen físico, incluyendo prueba de tuberculina y de sangre. El Sistema Transferencia de Registros de Niños Migratorios (MSRTS) y seguro de accidentes ha sido explicado y comprendo su significado. Yo se que los registros de mis niños estan a mi disposición y pueden ser obtenidos por mí, si es mi deseo. Además entiendo que estos registros serán mandados para otras escuelas en donde mis niños se matriculen.

I certify that the above named children moved with me from _____ to _____, WA on (date) _____, 19_____, while I or my spouse was employed or seeking employment in agriculture, horticulture, commercial fishing or a related food processing activity. My children have my permission to attend the educational programs designed to meet the needs of children of migratory workers. Furthermore, I give permission for my children to receive a physical examination, to include a tuberculin skin test and blood work (HCT). The Migrant Student Record Transfer System (MSRTS) and the accident insurance coverage have been explained and are understood by me. I know that my children's records will be made available for me to see and obtain if I should desire. I further understand that this record will be sent to other schools in which my children intend to enroll.

REVALIDATION DATE	SIGNATURE	/Date

PARENTS SIGNATURE OR GUARDIAN FIRMA DE PADRES O GUARDIAN

COMMENTS/
COMENTARIOS _____

INTERVIEWER _____ AGENCY _____ DATE SUBMITTED TO SCHOOL _____

White Copy - SCHOOL
Yellow Copy - MEIRP
Pink Copy - PARENT

Perfect Printing (Rev. 7-79)